AIDS in Central Africa – Is There Hope?
AIDS Intervention from a Christian Viewpoint

By Ernst H. Wendland & Katherine L. Wendland

CAPITAL LETTER DESIGNATIONS

ADRA - Adventist Development and Relief Agency
AHRTAG - Appropriate Health Resources and Technologies' Action Group
AIDS - Acquired Immunodeficiency Syndrome
AZT - Anti - HIV Drug
CAMM -Central Africa Medical Mission
CRAM -Churches Hospital Association of Malawi
CO - Clinical Officer
DANIDA - Danish International Relief Agency
HIV - Human Immunodeficiency Virus
LCCA - Lutheran Church of Central Africa
MAP -International Christian Health Agency, Evangelical Churches
MLRHC - Mwembezhi Lutheran Rural Health Clinic
NAPCP - National AIDS Prevention and Control Programme
NGO - Non-Governmental Organization
NORAD - Norwegian Government Health Agency
NPH - Northwestern Publishing House
PCI - Project Concern International
SITA - Swedish International Relief Agency
UN - United Nations
USAID - United States Agency for International Development
WELS - Wisconsin Evangelical Lutheran Synod
WHO - World Health Organization
YWCA - Young Women's Christian Organization
ZNASTL - Zambia National AIDS / Sexually Transmitted Diseases / Tuberculosis / and Leprosy Programme

PROLOGUE

Getting involved with a study of AIDS is like jumping recklessly into a bottomless sea that is all riled up with conflicting tides and crosscurrents. One hopes to be able not only to extricate oneself safely, but to find some kind of positive direction that makes it all worth the effort. Why take such a jump in the first place? Isn't there already more than enough information available on this rather disagreeable subject?

How did I get involved with the subject of AIDS to begin with? It so happened that I was suddenly exposed to several manifestations of its relentless, devastating power. I was hesitant, of course, to get involved, yet at the same time reluctant to ignore these experiences completely. How could one possibly be confronted with them, and like the priest and Levite simply "pass by on the other side"?

During my first years in Africa (1962 - 1978) the malady may already have been at work, but it had not as yet been identified. Returning to central Africa on a subsequent tour (1989 - 1993), it had not only been identified, but it was already wreaking havoc like a plague. The elite of African society were suddenly and mysteriously disappearing at the height of their productive years. Urban cemeteries could no longer find adequate space for the deluge of funerals. The AIDS epidemic, after several years of a hushed silence, was being openly recognized for what it was. Warnings against promiscuous sexual behavior were being heard, even openly warned against in daily newspapers and TV specials. Condoms were being sold on street comers, financed by various social agencies. Teenagers were being strongly urged in schools to say "NO." Yet life in Africa continued on its fatalistic way.

My own personal confrontation happened when I had to see a young man whom I had confirmed twenty-five years ago suffer through the agonizingly progressive stages of the disease, without fully realizing what was going on - or perhaps why. An experience like this can shake one, believe me, to a point where one feels that something must be done, even though one doesn't know quite where or how to begin.

At a subsequent gathering of missionaries in Peru in 1995 my wife Kathie and I became acquainted with Missionary Jim Olsen and his wife Mary, who had experienced similar confrontations with people suffering from AIDS. As we discussed the matter over breakfast coffee, Jim suggested that the Marvin Schwan Charitable Foundation could perhaps become involved in funding a study of the problem from a Christian viewpoint. The secular world was hopelessly bogged down in finding any answers, either morally or medically. The death rate in Central Africa alone made it imperative to see what God had to say about something like this. We agreed that Jim, who had some personal connections with those in charge of the Schwan foundation, should inquire if special funds were available. It developed that they would be interested.

I soon found that others were equally concerned. Our synod's Central Africa Medical Mission (CAMM), following afield visit by its committee in 1995, stated in its report that it was shocked by "the AIDS crisis in Zambia," asking in a subsequent report, "WHAT CAN WE DO ABOUT IT?"

Noting that secular groups such as British Aid, NORAD (a Norwegian Agency), and our own US AID (U.S. Agency for International Development) with their programs of "education" and "safe sex" have over the past decade experienced little impact in checking the spread of the disease, our CAMM committee requested that Deborah Teuteberg RN, FNP, dedicate her time of service in Zambia to "assess needs and make recommendations to approach the AIDS crisis from the perspective of Scripture."

The CAMM Committee took a further step, asking Joanne Halter, a licensed social worker and director with Wisconsin Lutheran Child and Family Service, to continue this study toward developing "a program to counsel and care for those infected with HIV in Zambia."

The above short-term assignments together with my own inquiries have been conducted in cooperation with our synod's Central African Executive Committee, the WELS missionaries in Zambia, the Lutheran Church of Central Africa, and with the staff of our Mwembezhi Lutheran Rural Health Centre, all concerned about how the problems relating to the AIDS crisis can best be dealt with, both medically and spiritually. I appreciated especially the personal interviews with the following, whose work and life in Central Africa have brought them into close contact with people affected by the AIDS epidemic: Pastor Samuel Kawiliza, Chairman of the LCCA, Zambia Conference, Professor Salimo Hachibamba, Principal of the LCCA Seminary, Sylvia

Gustavison, Nurse Administrator of the Mwembezhi Lutheran Rural Health Centre, Alfred Mkandawire, Clinical Officer at the Health Centre, the pastors of the LCCA, Dr. Ernst R. Wendland, Language Coordinator of the LCCA, his wife Margaret Wendland, Nurse Administrator of the U.S. Embassy Health Clinic, Missionary Mark Wendland and his wife Louise, who assisted with our research in Malawi, and, of course, my wife Kathie, who has collaborated with me in all parts of this study.

So I find that I'm by no means alone in this investigation of AIDS intervention from a Christian viewpoint. Those whom I have interviewed in America and Africa have been eager to help. Other health agencies and church organizations have been more than willing to share information. In addition to all this, Dr. Heinz R. Hoenecke, a member of our WELS Board for World Missions, President of Pathologists Overseas, and a frequent visitor to Africa, has been willing to help with his professional expertise and professional connections.

What follows, therefore, has been the result of a cooperative undertaking, in which things have come together far better than I might have expected at the outset. In fact, after Kathie and I returned from Africa and completed our report, there have been many requests from various sources to see the results of our study. We are therefore making it available through this pamphlet, sharing the information we have gained with anyone interested.

There are many kindred spirits willing to wrestle with a problem that has so far baffled medical science. We are thankful for the tremendous effort that medical science has been devoting to this crisis. We feel, however, that the problem is more spiritual than medical. We are convinced that there is a vital ingredient which the world with all its wisdom cannot supply. That is, of course, the Christian viewpoint.

THE ABCs OF AIDS

There's the story, of course, about the lecturer on AIDS confronting a group of teenagers with the question, "How many of your know the ABCs of AIDS ?" The class stumbles about and fails on "A" for "Abstain," and on "B" for "Be Careful," but on "C" they shout all too quickly: "Condoms," instead of "Continence." Maybe that's a poor aside, but we want to be sure everybody knows that these ABCs are definitely not what we're referring to here.

We're concerned in this chapter more about trying to explain the rather complicated acronymic terminology of HIV/AIDS, as well as its transmission and cure, in an understandable "ABC" kind of language.

AIDS Terminology

When beginning a study with the use of AIDS terminology, one is confronted with technical terms frequently used, but little understood by the average individual unschooled in medical parlance. The writer heads the list of the non-professionals. It follows, then, that we start from scratch, relying upon experts who can give us simple definitions of what the ABCs of AIDS are all about.

Lets begin with the word itself: AIDS.

A stands for "acquired." This means that AIDS is a disease that a person gets from somebody else. It cannot be inherited. It does not result without definite cause, or simply from getting old. You "catch it." Somebody with the sickness gives it to you. It is therefore "acquired."

I D stands for "immunodeficiency." Whoever conjured up this term not only gave us a jawbreaker, but also complicated things by confronting us with a compound word consisting of two parts, namely "immune" and "deficient." The "immune" system of the human body has the ability to fight off infectious diseases, like pneumonia, influenza, or tuberculosis. To be "deficient" in one's immune system means that one's body is not able to ward off diseases that it would ordinary be able to fight off successfully.

S stands for "syndrome." This word simply means "naming together." In the field of medicine it refers to a number of symptoms "running together." Indicating that something is wrong. This can be any number of

things—a high fever, a cough, a sore or infection, a loss of weight—things that persist with no apparent cause, but just won't go away. Why not?

Here we come to another acronym: HIV.

H stands for "human." Whatever we're dealing with affects human beings. We're referring to people, not animals.

I, as mentioned previously, stands for "immunodeficiency." Again the fact is emphasized that the problem lies with an immune system that is deficient, weak, unable to fight off disease. This time the cause is designated with another letter: V.

V stands for "virus." A virus is not the same as bacteria. All viruses live inside a set of one's body cells. The virus makes these cells malfunction, and one becomes sick. Normally one's immune system attacks these viral body cells to get rid of them. It produces what are known as antibodies, that fight against the virus. In the case of AIDS, however, the virus not only makes one sick. It even attacks the cells of one's immune system, destroying the very system that fights against disease.

So there we are. For the present we'll keep it simple. HIV is the viral cause of it all. AIDS is the resulting disease. When a person's immune system because of the HIV virus can no longer fight off the disease, the person dies of AIDS with its complications, including various infections such as tuberculosis and other malignancies.

AIDS Transmission

But wait a minute! Doesn't this immediately suggest a situation so fearsome that everyone is suddenly placed into a hopeless state of jeopardy? Here we have this mysterious HIV virus, so far not even identified, increasing by leaps and bounds, destroying immune systems, so that people are dying of AIDS like flies. How can one be protected from the plague? Must we avoid all contact with people infected with AIDS? How do we even know who they are? Yes, what about those especially living in areas where the disease is so widespread?

The answer lies in the transmission of the AIDS virus. HIV does not spread in the ordinary way, like through having the flu, or a cold. It is not passed on by casual contact; like breathing in someone else's face, or shaking hands, or sitting on the same toilet seat. Those living in Africa may be relieved to know that even mosquitoes, ticks, and insects that suck blood are not transmitters of the AIDS virus, since these creatures only take blood and do not inject it back into someone. (This statement appears frequently in HIV/AIDS literature, but to date I haven't seen any precise documentation of it.)

It is transmitted only through direct contact with someone else's blood, or through bodily substances containing HIV passed on from one person to another (semen, vaginal secretions, breast milk).

The most common ways of HIV transmission, therefore, are the following:

1. Sexual intercourse (both homo- and hetero-);
2. Use of infected syringes and needles;
3. Blood contact or transmission;
4. Childbirth and breast milk.

The time required for HIV to develop into AIDS varies anywhere from a year or two to as long as ten years.

Symptoms of HIV infection are: severe case of high fever, skin blotches, persistent sores and infections, swollen glands for no apparent reason, diarrhea, recurrent flu-like discomfort, nightsweat, and sudden loss of weight.

Those experiencing recurrent symptoms of the above kind can be medically tested to determine whether or not they are HIV+.

AIDS Cure

At the present time there is no cure for AIDS. No vaccine has been found for its prevention. Scientists are at work, of course, to develop effective medicines to counteract its devastating results. One is constantly hearing news reports of their latest findings, promising possible "breakthroughs." AZT, the original anti-HIV drug, has recently been accompanied by what are called "protease inhibitors." Three of these have been given in combination to provide a one-two punch, since a virus resistant to one drug might be wiped out by one of the others. It is estimated that these new drugs cost about $600 a month, provide relief for only a comparatively short period of time, and in the final stages with hospitalization could cost the patient well over $10,000 a month.

In spite of magazine stories about people with HIV "doing just fine" (*US News and World Report*, February 12, 1996, "Beating the Odds"), in spite of reports about HIV-positive athletes still competing successfully, in spite of scientists and survivors making "striking progress," the many news polls conducted in the US still rate AIDS as "the nation's greatest health problem."

There is still not a cure; a vaccine is nowhere in sight.

Good News - Bad News

The "good news" about AIDS, expressed in ABC form, lies in this knowledge concerning its transmission. Attached, of course, is the great big "IF":

- If people could control the problem of promiscuous sex;
- If people could abstain from the use of drugs with infected needles;
- If people would exercise care with blood contact and blood transfusion;
- If people would avoid contact with bodily secretions of infected persons—

If these could be successfully controlled, it naturally follows that the number of new cases of AIDS would drop to zero. We have this knowledge. And for Christians this is nothing new. God has expressed these basic principles so clearly in his word. Yes, we have this knowledge. There is no reason for us to fear. We won't get AIDS if we follow what he has told us. People can control its transmission if they do what he says.

The "bad news," on the other hand, is that many people do not know what God says in his Word, or if they do know, either consider it to be foolishness, or fail to heed it because of their own sinful appetites. Their flesh overcomes their spirit. Human beings, born under the curse of original sin, are their own worst enemies. That's the "ABC" of it all. Isn't it ironic that the abuse of God's precious earthly gift, the gift of sex, should become the most destructive bane of mankind's earthly existence!

When the LORD God came to fearsome, confused Elijah in a cave at Horeb, he revealed himself not in a great and powerful wind that tore the mountain apart, not in an earthquake, not in a fire, but in "gentle whisper" (1 Kgs 19:11-12). Our purpose in this entire study will be, finally, to make use of this "gentle whisper" of God's voice whenever and wherever possible to counteract what is bad about AIDS with that which is good.

This is the purpose of our study of AIDS intervention from a Christian viewpoint.

AIDS - A PUBLIC HEALTH DISASTER

Statistics - Statistics

Whether we like it or not, we're living in a world that places great emphasis on statistics. Planners in the fields of business, politics, and even church growth often develop their strategies on the basis of statistics. Attempts are made to prove just about anything by the use of charts and graphs, sometimes to our chagrin. I can remember a devoted mission planner using numbers and diagrams to assure his audience that a certain venture could become self supporting within less than a decade. His figures were impressive. His persuasiveness convinced his hearers. Although we can be thankful that his arguments had much to do with entering a promising world mission field, we are still supporting this field nearly fifty years later to the extent of thousands of American dollars annually.

One sometimes has to wonder how certain statistics are arrived at in the first place. How can one make predictions involving countries with millions of people, located thousands of miles away, when some areas within these countries are almost impenetrable? How can one conduct a survey in an urban situation, and then say that the same percentages apply generally, even out in the bush?

Since some rather startling, yes, even shocking statistics have been used in connection with AIDS, one may have to allow that some of the figures that follow can be designated as "educated guesses." Yet "educated" they are, coming from recognized sources. They are not based on thin air. They reflect distressing conditions which cannot be ignored. It might also be added that those who report these AIDS statistics invariably state that they do not reflect the actual epidemiological situation in the country; if anything, the figures are underestimated.

Statistics Referring Especially to North America

According to the latest reports available to us from the World Health Organization (WHO), it is estimated that there are over 20 million people in the world today infected with the AIDS virus. Some 6,000 people become infected each day. In the United States, the Center for Disease Control (CDC) reports that there are about 1 million people infected with the HIV virus, and nearly 300,000 AIDS cases.

Half of HIV infections in America are among people under 25 years, with 60% of infections taking place by the age of 20. Not only women are involved, but their children to whom this disease is transmitted.

Cases due to homosexual sex exceed those among heterosexuals by 3 to 1. Cases resulting from intravenous drug use lie somewhere in between. Cases among men are 5 to 1 higher than among women, with whites and blacks about on an equal level.

About 30% of those with HIV result in "full-blown" AIDS within the first 5 years, 50% within 9 years, and 25% within 10 to 12 years. One has to wonder what all this bodes for the future.

A recent report authorized by U.S. President Clinton notes that every year between 40,000 and 80,000 Americans become infected with HIV. Approximately half of those infected are under age 25. This means that between two and four young people are infected with HIV every hour of every day.

This report was requested by the president and prepared by Patricia Fleming, White House AIDS policy chief. It highlights the fact that the most vulnerable people at risk are the youth, the teen-agers, especially the runaways and those out of school. The report highlights "education" as the key to stopping AIDS. It pleads for HIV testing and counseling. It appeals to communities, public and private institutions, to become "actively committed to combating the spread of HIV among America's youth."

There is much truth in this report. "Education is the key... knowledge is power." But all the education and all the knowledge in the world are not going to solve the problem if they do not lead to a kind of behavior based on the basic principles given in God's word.

Statistics Referring to Africa, Especially Zambia

In countries of central Africa, epidemiologists estimate that there are 1,000 cases of AIDS per one million population (WHO). In sub-Saharan Africa an estimated 4 million men and 4 million women are living with HIV+. This means, of course, that the incidence of HIV infection in Africa is considerably higher than in North and South America and in Europe.

Among African countries with high prevalence of AIDS, figures based on percentage of those afflicted place Zambia second on the listings, with Rwanda first, and with Kenya rated as number three.

According to Ministry of Health reports in Zambia 400 to 500 people are newly infected by HIV each day. In 1993 the total of HIV infected adults was between 600,000 and 700,000, with peek incidence expected between 1998 and 1999. An estimated 250,000 people will die of AIDS between 1994 and 1998, 320,000 children will be orphaned, and 700,000 new individuals will be HIV infected. A sort of "ballpark figure" generally bruited about is that one out of three people in Zambia is either infected, or in serious jeopardy.

Individuals with AIDS needing extensive care in 1993 were 70,000 individuals, with an estimated 150,000 needing this care in 1998. In Zambia at least 700,000 children are living on the street. Of these 140,000 are orphans, with 600,000 orphans expected by the year 2000.

A source of extreme concern lies in the fact that the majority of HIV/AIDS sufferers in Zambia are young adults, usually between 20 to 29 years. These are the educated, the skilled, the people in the prime of life, experienced leaders in the community. The capable, in other words, are being destroyed. The young and the old are being left behind. What will eventually happen to the country's industrial and educational development is not difficult to figure out.

A Christian Viewpoint Needed

It is one thing to read these shocking statistics, shake one's head rather noncommittally, and wonder why or how the world ever got into such a mess. One can perhaps breathe a sigh of relief when not being included among such numbers. It is quite another thing, however, to actually see the results of those who are suffering.

Either in America or central Africa, one asks what's it like to see a friend or a relative grow gradually weaker, experience brief times of remission, only to become weaker with the next setback, aware that he or she will never recover, hurting, losing weight, shivering under a pile of blankets, finally becoming disoriented, with vital organs ceasing to function, being for death, lapsing into a coma never to speak again? In the course of my ministry I've been with people in the final stages of lung cancer, muscular dystrophy, prostate cancer, and other types of malignancy. But AIDS cases are the most stressful of all.

What's it like to attend a church service in which people who once loved to sing find it difficult to raise their voices in song, even no longer finding the strength to stand up for the liturgical parts of the church service?

What's it like, finally, to serve in a medical facility where the patients have no future, no time to look forward to, are withdrawn, guilt-ridden, weepy, hopeless, and helpless?

These situations require more than pious platitudes or empty promises that things might some day get better. In addition to requiring an extraordinary measure of loving care and compassion, one must face the ultimate questions relating to life and death and eternity. How can a loving God permit this? Is this possibly his judgment upon some particular sin? Can one speak of any kind of hope at all, or of a fulfillment of purpose? When all social, economic, and domestic values disintegrate, are there any that remain?

Here, of course, is where the "Christian viewpoint" fits in. God has not left us without answers. We do have some very positive answers, unfortunately very often unknown or ignored. It was interesting to this writer that in a recent "AIDS Bibliography" listing 102 books on the latest studies, only three referred to any kind of Christian counseling. I checked one of these "Christian" treatments, finding it totally lacking in any Scripture references, while warning strongly against "fundamentalistic views" which could have the potential of "offending tender sensibilities."

There are those, however, who regard the clear teachings of Scripture as the voice of God, and who will want to listen to what he has to say in his word.

AIDS INTERVENTION AND THE BIBLE

Hear the Word of the LORD!

Ezekiel's ever-recurring cry serves as an excellent admonition for this chapter as we continue our study of Aids Intervention from a Christian Viewpoint. We've waited long enough. Let's get to the heart of it. "Hear the word of the LORD! This is what the Sovereign LORD says" (Ez 13: 2-3). Whenever the NIV edition of the Bible uses capital letters for the word LORD, it refers to the "I AM" LORD, who revealed himself to Moses as the God of the covenant, serious about obedience to his commands, yet gracious about keeping all his promises. He's a God who's worth listening to! Without his guidance, our labor is in vain.

Ezekiel had some unpopular things to say to the people of his time. Exiled in Babylon, he served as a prophet to proclaim a message to those who had substituted calf worship for honoring the God of their fathers, who had defiled God's sacred temple, indulged themselves in heathen fertility rites, and by their ever increasing moral corruption had brought God's severe judgment upon themselves. A time of repentance had come. "Hear the word of the LORD," before it is too late.

As Lutheran Christians we believe that the Bible is the inspired word of God. We believe that it is inerrant, not subject to all sorts of conflicting interpretations. Also in connection with the basic moral principles relating to life and death, our God speaks to us clearly and unequivocally. We need to listen to his voice, especially in times of stress, when his hand lies heavy upon us.

Without this firm conviction we could forget about our own little study of AIDS, wait indifferently for the next "breakthrough" sought by medical science, and let it go at that. Our God, however, has not left us without some very basic guidelines according to which he wants us to conduct our lives. He reminds us that his way is the right way, and that if it is disregarded, we'll suffer the consequences.

Especially as his children he has given us some very clear answers as to how he wants us to cope with this messy conundrum that humanity has brought upon itself by its immoral behavior.

Marriage

From the LORD's superior viewpoint it doesn't take a lot of searching and striving to know where the basic problem lies in this entire matter. When in the beginning God created people, he made them "male and female" (Go 1: 27). The very crown of his creation was a married couple, one man and one woman. He united them in marriage to "become one flesh" (Ge 2: 24), a biblical phrase referring to the close sexual relationship existing between the two. He blessed their union with children to "fill the earth and subdue it" (Ge 1: 28).

After mankind's tragic fall into sin, God continued to protect this institution with one of the ten commandments of his moral law, given on Sinai with a loud voice and engraved in stone. "I am the LORD your God, who brought you out of Egypt," he reminds them as their Maker and Redeemer. "You shall not commit adultery" (Ex 20:14).

The Lord Jesus in his earthly ministry reiterated this commandment several times (Mt 2: 24; 19: 18). In both the Hebrew and Greek languages originally used in Scripture, to "commit adultery" literally means to "break marriage." Jesus also reemphasized the fact that in marriage husband and wife would "become one flesh." They should "not separate" what God had "joined together" (Mt 19: 5-6).

From the standpoint of Scripture there is no question but that the great blessing and privilege of this sexual intercourse is not something to be indulged in outside of the marriage covenant. "Marriage should be honored by all," we read in Hebrews 13:4, "and the marriage bed kept pure, for God will judge the adulterer and all the sexually immoral."

In the Old Testament, adultery was punishable with death (Lv 20: 20). All types of sexual relations outside of marriage were strictly condemned (cf. Lv Ch 20). The New Testament not only warns against breaking the marriage covenant, but also considers any relationship outside of marriage as immoral (1 Thess 4: 3- 5; Eph 5: 5). All impure words and thoughts referring to illicit sexual relations are strictly forbidden (Eph 5: 3-4; Mt 5: 27-28). A Christian is to regard his body as "a temple of the Holy Spirit," and should therefore "flee from sexual immorality," which would be a sin "against his own body" (I Cor 6: 18-19).

One could, of course, cite many other Scripture passages to show God's will for the sanctity of the marriage estate, and which express his guiding principles concerning it. Those given here should suffice. They clearly show that the Bible restricts sexual intercourse to the marriage covenant, also forbidding all impure words, thoughts, and actions which desecrate this divine institution in any way.

Homosexuality

AIDS and homosexuality are interrelated. It was among the gay community in 1981 that the disease was first identified in America. Homosexuals ever since, especially in America, have been reported as those "most susceptible" to this affliction.

The Bible frequently refers to homosexuality as "the sin of Sodom," since it was there that this kind of sexual relationship was first reported (Ge 18: 20; 19: 1-11; Is 3: 9; Dt 32: 32; Lam 4: 6). In the disgusting account in the book of Judges concerning the Levite in Gibeah, it is referred to as men "having sex with men" (Jdg 19: 1-22).

The Old Testament law of Moses explicitly condemns homosexuality as "detestable," punishable with the death penalty (Lv 18: 22; 24: 13). The apostle Paul in the New Testament refers to "homosexual offenders" as among those who "will not inherit the kingdom of God." Michael McKenzie writes that the biblical evidence against homosexuality is "so overwhelming, that most modem theological liberals are at least honest enough to admit that the Bible does indeed condemn homosexuality" (AIDS: Reaping the Whirlwind, *Christian Research Journal*, Summer 1993).

We trust that this array of Scripture passages will be sufficient to convince anyone who takes the Bible seriously that marriage is the only legitimate place for intimate heterosexual relations, and that homosexuality is an unnatural and shameful defilement of God's purpose for sex.

Some Basic Conclusions

It follows, then, that if homosexuality is definitely off-limits, and if heterosexuality is limited to the two partners in marriage, AIDS can be kept under control. It also goes without saying that the chief cause of the AIDS problem lies with transgressing the very purpose for which God instituted sexual partnership, and with contravening the moral standards set by God to regulate marriage.

It is distressing when we read and hear advice about so-called "safe sex" contained in the materials given by many agencies claiming to be of help in this matter. There is really only one kind of "safe sex." All the reams of pamphlets and millions of dollars spent in encouraging and educating our young people in the use of condoms, also supplying them freely with the same, only makes things worse. Not any does it give questionable information about "safeguards." It also adds to a sinful practice that goes contrary to a basic principle ordained by God himself.

With all these good intentions are our people really hearing the word of the LORD?

The Valley of Dry Bones

It was typical of Old Testament prophets to attach words of the LORD's gracious assurance to his stem warnings and urgent calls to repentance. Ezekiel was no exception. Thus he who was used by the LORD to bring words of wanting, also brought beautiful words of promise.

In a valley of dry bones God showed Ezekiel how his spirit could breathe into these dry bones and could bring a vast army of people back to life. This is one of those striking passages of Scripture. It closes with the words of the LORD, "I will put my Spirit in you and you will live, and I will bring you in your own land. Then you will know that I the LORD have spoken, and I have done it," declared the LORD (Ez 37: 1-14).

How comforting that must have been for Ezekiel, living in exile, wondering how life could ever be restored again to a land which had been destroyed, and to a people which had been carried away into exile! We know how the LORD brought this incident to its final fulfillment in the gift of his one and only Son, in the sending of his Holy Spirit, and in the establishment of his Holy Christian Church of the New Testament.

The LORD has promised us that same Spirit. We have that word of life, and truth, and hope, through which that Spirit works. Sometimes we get discouraged. In our own land America we see a breakdown of morality, a weakening of "civic righteousness." The family, the basic unit of society, is breaking down. Those taking drugs are on the increase. Our young people are finding their companionship in gangs. Indulging in sexual immorality has reached a point where one wonders where it will lead. The latest cry, heard recently, is to legalize gay marriages. How can AIDS ever be brought under control with all such things going on?

In parts of Africa the same plague has put nearly a third of the population on death row. Although more of a heterosexual than homosexual problem on that continent, there are many cultural difficulties connected with native law and custom that enter the picture. We hope to refer to these things later on in our study. Our own people, of course, to whom we have been privileged to bring the gospel, are living wider these same difficult circumstances. Where and how will it end?

We need to remember that the same LORD who chastises, can also heal. He who permits stern judgments to take place, can also breathe life into dead bones. There is hope, eternal hope, which only his Spirit can bring through his word. Whatever we can do to help bring this spiritual help to our brothers and sisters in Africa, should be our final emphasis in our study of AIDS intervention from a Christian viewpoint.

What has been written so far on these pages has been in preparation for a trip to Africa to see for ourselves what has been happening there. We want to go to Africa and speak with the people themselves, with the leaders of our national church, with pastors, with the missionaries with government agencies, with other church bodies, with the many organizations that are already involved in this struggle. We want to hear directly what they have to say. Above all we want to do this under the influence of the LORD's word, asking his Spirit to guide us in whatever we do.

Finally, we know that all our plans, our hopes, and our resultant programs and our projects hang together with what God has to say and help us do. As we've mentioned before, the problem is medical, but at the same time more spiritual than medical. Only the LORD can breathe life in dead bones. Only he can bring help, when all other helpers fail.

ON THE ZAMBIAN SCENE AT LAST

Although HIV/AIDS is a world problem, central Africa, including Zambia, has been the area most seriously affected by it. Having spent 21 years of my ministry in Zambia, it was by no means a strange place for Kathie and me to undertake this study of AIDS intervention.

In a way it was for us like "going back home." Son Ernie, language coordinator of the Lutheran Church of Central Africa and professor at the Lutheran Seminary in Chelston, Lusaka, offered the use of his home on the seminary property while he and his family were on furlough in America. Daughter-in-law Margie was more than happy to have Kathie substitute for her in her work at the medical unit of the American embassy in Lusaka. Through helping out with teaching at the seminary, and with Kathie coming into contact with people at the embassy, we were in ideal situations to meet and talk with those who could help us with the information we were looking for.

I had previously asked Margie to scout around at her workplace for information that might be helpful in a study of the HIV/AIDS matter. Having served for over two decades as nurse in the medical unit of the

embassy, Margie was no stranger to the situation. She had waiting for me a stack of papers, booklets, reports, and various materials that left me wondering if I'd ever be able to sort through it all.

What a bonanza! It took me several days just to scan through all the materials, opening my eyes to the fact that more was being done in Zambia about the HTV/AIDS problem than I could have possibly imagined. Thank you, Margie! It certainly saved a lot of time finding out where to go for this kind of input. What follows is a summary of the chief sources of governmental and societal information relating to the HIV/AIDS situation in Zambia.

Government Action

Although already in the early 1980s the HIV/AIDS problem was present in Zambia, not much was done about it publicly. However, when President Kenneth Kaunda's son David died of AIDS in 1986, he became a leader among heads of state south of the Sahara in supporting efforts toward combating the disease.

In 1986 the Zambian government established the National AIDS Surveillance Committee, and an International AIDS Health Committee to coordinate all activities of AIDS prevention and control in the country. Frequent workshops were held to develop strategies to deal with vulnerable groups, especially women and children. AIDS prevention programs, community care for AIDS patients, marketing condoms, training AIDS counselors, organizing AIDS clubs etc. were all a part of the strategy. The World Health Organization (WHO) donated the sum of ten million dollars toward this program's support, with the following countries participating: Sweden, Norway, Canada, United Kingdom, Netherlands, United States, Denmark, France, Japan, and United Nations agencies.

An Emergency Short Term Plan (STP) was also implemented by the Zambian government, to ensure a safe national blood-bank supply. A five-year Medium Term Plan (1988-1992) was inaugurated "to identify priority strategies." Interventions were placed under the supervision of the National AIDS Prevention and Control Programme (NAPCP), to carry out laboratory support, epidemiology and research, counseling, home-based care, sexually transmitted diseases, and clinical care.

When in 1992 it was reported that "the impact in curbing the epidemic fell short," Medium Plan II was inaugurated for the 1994-1998 period. This plan concentrated on promoting education through various social agencies to prevent transmission of HIV, using informational booklets prepared for schools, workplaces, and selected groups, and to expand condom distribution.

A Strategic Plan was also developed to shift the emphasis of health care by working on a more "multi-sectoral basis," covering all the provinces of Zambia rather than concentrating on urban areas, and including offer diseases order a Zambia National AIDS/STD/TB and Leprosy Programme (ZNASTL). A 35 page prospectus outlines this program.

A five-year million dollar grant from the US Aid Program (US AID) is funding this effort, with the goal of "training 35,000 workers, primarily educators in the public-private sector, 2,400 traditional healers, 7,000 out-of-school youth, 1,750 key adults and 80 media persons." A "social marketing program" had as its target the sale of 30 million condoms.

President F.T.J. Chiluba set the tone for World AIDS Week in a speech on November 24, 1995, encouraging Zambians and the world at large "to look at HIV/AIDS as a serious problem which can no longer be denied, trivialized, or ignored." He urged Zambians to "share in the responsibility of protecting themselves against HIV/AIDS and to respect the human rights of all people."

Zambia, in short, has been no stranger by any means to HIV/AIDS intervention. On paper, at least, its government has been trying to do everything possible to combat the spread of the disease. Other countries, including the United States, have been subsidizing this activity to the extent of millions of dollars in grants. Publications of every possible type have been made available. The big question remains, of course, as to how much of this material has been getting through, and what effect all these efforts has been having on the people.

(At this point the original report contains a listing of the publications produced by government and other agencies in connection with the AIDS program. While this list may not be of interest to some readers, they are

included here to give some idea of the tremendous effort put forth in an effort to cope with the problem, as well as to offer a source of information to anyone wishing to make a more detailed study.)

A. Publications Explaining the Government Program

1. *Common Questions and Answers on HIV/AIDS/STD/TB*, printed by ZNASTL, 30 pp Explanations of AIDS in ultra-simple English, how it develops, how transmitted, how it is treated. Advice is given on counseling and use of condoms.

2. A series of Guides developed in conjunction with NASTL, made possible through support by Morehouse School of Medicine, C.A., Zambia Bureau for Africa. These guides are designed to train managers and peer educators in various workplaces to help prevent the spread of HIV/AIDS.

a. *Peer Educator's Guide*, Illustrated, 35 pp.
b. *Programme Coordinator's Guide*, Illustrated, 21 pp.
c. *Reference Guide 1 for Peer Educators*, Illustrated, 50 pp.
d. *Reference Guide 2 for Peer Educators*, Illustrated, 32 pp.
e. *The Manager's HIV/AIDS Manual*, Illustrated, 15 pp.

3. *The Socio-Economic Impact of AIDS*, a Zambia Ministry of Health document prepared to give detailed-information on the AIDS situation in Zambia up to 1993, with projections based on demographic changes, 67 pp. (Supported by NORAD and SITA.)

B. Publications from Other Agencies

1. *Anti AIDS Club Magazine*, produced for young people, especially school dropouts, streetkids, and those not in formally-organized groups. It offers suggestions for discussing sexual behavior by means of drama, story-telling, puppetry, letters etc., oft in comic-book style illustrations. Address:
Anti AIDS Project, Private Bag RW 75 x
15102 Ridgeway, Lusaka. Tel: 223589

2. *Let's Talk About It!*, a magazine issued by YWCA of Zambia in conjunction with the Zambia National AIDS/STD/TB and Leprosy Programme (NASL), through support provided by the Morehouse School of Medicine, C.A. This promotes teenage discussion of various problems relating to AIDS, as well as information relating to "safer sex by use of condoms," and "staying well with HIV." Address:
YWCA, P.O. Box 50115
Nationalist Road, Lusaka. Tel 254751

3. *Dr. KALULU Says*, an illustrated pamphlet with AIDS facts for primary schools. Address:
Anti-AIDS Project (see above).

4. *AIDS and YOU!*, an illustrated tract issued periodically, for free distribution to secondary school students, produced by the Zambia Red Cross and Anti AIDS Project. Address:
The Zambia Red Cross Headquarters
P.O. Box 50001 Ridgeway, Lusaka. Tel 250607

5. *AIDS Action*, an international newsletter on AIDS prevention and care, Southern African Edition, published by Appropriate Health Resources and Technologies Action Group. This is issued quarterly, with regional supplements. Address:
AHRTAG, 29-35 Fairington Road

London ECIM, UK. Tel : +441710041

6. *Front Lines*, A Zambian HIV/AIDS Newsletter, published bi-monthly by Kara Counseling and Training Trust. KARA HOUSE, THORNPARK HALL, CHAWAMA CENTRE, BAULENI CENTRE and HOPE HOUSE are all located in Lusaka, offering HIV/AIDS counseling and testing, training courses in counseling skills, and information in education outreach programs. Address:

Kara Counseling and Training Trust
Cha Cha Cha Road South-End
P.O. Box 37559, Lusaka. Tel : 222761/229847/224121

There are other publications such as AIDS Brief, an international newsletter published quarterly by MAP International, a Christian agency "committed to promoting health as spiritual, Status and Trends of the HIV/AIDS Epidemics in Africa, an interesting report on a workshop held in December, 1995 in Kampala, where 30 epidemiologists, demographers, economists, and public health experts from Africa, Europe, and North America agreed that "surveillance must improve to check the relentless spread of AIDS," and a catchy *AIDS Flip Chart*, produced by the Morehouse School of Medicine, a teaching aid large enough for audience use, with illustrated scenes depicting situations that could lead to possible heterosexual encounters. Questions are given on the backside of each illustration, to encourage group discussion. In fact, the amount of materials produced for HIV/AIDS educational and promotional materials seems endless.

The United States Department of Health and Human Services (USAID) has quite recently prepared a booklet listing kits, displays; brochures, reports, counseling guidelines, videotapes, computer diskettes, and reference materials, available at a unit price to cover shipping and handling. The address is CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003. Anyone requesting scads of materials can obtain them for the asking.

Just recently, after arriving in Zambia, I received a stack of materials from Macmillan Publishers (Zambia) Ltd., in connection with a new venture called The Macmillan Aids Awareness Programme. This is "an AIDS education programme between the ages of 10 to 18 years," consisting of six illustrated booklets for children between 10-15 years, (Primary Grades 5 and 6), and 12 of the same for children between the ages of 13 to 18 (Primary School Grade 7 and Junior Secondary School Grades 8 and 9). These come with a Teachers Guide and reference books on family planning and management of AIDS patients.

The Managing Director of Macmillan Zambia happens to be Miles Banda, a member of our Lusaka Lutheran congregation and the treasurer of the Lutheran Church of Central Africa. The address of this company is: Macmillan Publishers (Zambia) Ltd., Plot No. 96 Mutandwa Road, Roma, P/Bag RW 348x Ridgeway, Lusaka, Tel 292049/292924.

Mr. Banda pointed out to me that the booklets introduce the subjects treated with interesting stories that appeal to African children, followed with questions for the teacher to encourage discussion. Although produced in South Africa, they have been adapted for use in Zambia.

Margie's Reactions

What an impressive compilation of materials! One can't help being impressed by the number of governmental and social agencies involved in these educational programs, and by the amount of materials that they have already prepared. Thanks again, Margie, for gathering all this for my perusal! It certainly saved me a lot of time.

I was also very much interested in Margie's personal reaction to all this. She's "quite a gal." She has a way of "telling it straight." Having been directly involved in medical and counseling work at the US embassy for over twenty years, and having known personally many of the people associated with these programs, I value her opinions.

Margie was equally impressed, of course, by all the activity associated with HIV/AIDS intervention efforts, but stated quite frankly that she was frustrated at times by the whole situation. Here are a few snatches taken from various parts of the taped interview with her:

> In spite of all the activities reflected in the materials I've kept for you, there doesn't seem to have been much change in people's behavior .... We're being buried in information, but why are the statistics going up? Why aren't people changing? Are we hitting the wrong groups? . . I can't ignore seeing so many people whom I love dying. It's devastating to see things going on which should be avoidable . . . . The center of society is being eaten out. The old, the young, and the sick are going to be the only ones left! . . . Are we wasting our breath?

It isn't that Margie rejected out of hand the efforts being put forth by various agencies and organizations. Her objections were chiefly that the people on the one hand weren't listening to the warnings and the advice being given, and on the other hand were to a great extent receiving a type of information that didn't strike at the root of the problem. In summary, much of the information stated that a monogamous relationship is the ideal, but that if it's too difficult to manage, be sure to practice "safe sex" and use condoms correctly. The emphasis was on physical healing without dealing with the moral weaknesses that were the underlying cause of it all. "Sexual activity in Africa," she pointed out, "begins with twelve year olds, and is a part of getting married. Parents must teach their children to keep them safe. This involves sacrifice on the part of parents and children. It demands a change in behavior from what is happening in Zambia today. It involves love, a love that begins with God and which leads to doing what he tells us in his word. Behavior based on fear is self-defeating."

Margie's concluding words received on tape bear repeating: "Without God's word there is really nothing of much of importance to say. Without him we're confronted with a bottomless pit, not knowing where to begin or end. But with God we're not dealing with the impossible. He loves us, and wants us to do what he says, or suffer the consequences."

Does this sound too idealistic? I don't think so. To me the problem is behavioral, based on moral principles, rather than organizational and physical. In this respect, if one is permitted to branch off a bit, we in America need to set our own house in order before presuming to tell others what to do. Take for example the latest issue which confronts our country, that is whether or not our government should grant civil marriage licenses for gays. I like what William Bennett says on this in a recent issue of Newsweek (June 3, 1996), "A legal union of same-sex couples would shatter the conventional definition of marriage, change the rules which govern behavior, endorse practices which are completely antithetical to the tenets of all the world's major religions, send conflicting signals about marriage and sexuality, particularly to the young, and obscure marriage's enormously consequential function, which is procreation and child-rearing." Maybe a little more of this kind of "civic righteousness" is what we need to hear.

We'll have more to say about all these things, no doubt, as we get into our interviews with the people here.

AN INTERVIEW WITH THE LCCA CHAIRMAN

It is one thing to study all sorts of reports on certain situations and problems. It is quite another to hear directly from those who are living daily with these problems, those in the thick of it all. Both Kathie and I took every possible opportunity to sit down with a tape recorder and interview as many people in Zambia and Malawi as possible. Our first taped interview was with Pastor Samuel Benford Kawiliza, chairman of the Lutheran Church of Central Africa, Zambia Conference. I felt it would be appropriate to begin with the president. "Sam," as I know him, is the son of one of the first students at our Bible Institute and Seminary at Chelston. I knew Sam already as a child, growing up on the property here. His father Benford is now retired, having served over 20 years as a pastor in the LCCA. Sam followed in his father's footsteps, and has recently been elected chairman of the Zambia Conference of the LCCA. He is married, with four children ranging in

ages from two to eight. For a young man in his early thirties Sam has big responsibilities, and he is measuring up to them well. Sam was well prepared for the interview. My son Ernie had previously informed him of my coming, and that I would be asking some questions. As a result we began with him doing most of the talking, without any prompting. He had two points which he wanted especially to emphasize (his statements which follow are paraphrased):

> The first thing I would like to speak about are family values. There has been a serious breakdown of family values in central Africa. Formerly, according to our African culture and tradition, the children were brought up to respect their elders. In what we call *chisungu*, the girls were taught by the women how to take care of a home, and how to please their husbands. The boys in many areas like the Northwest Province of Zambia learned about family life through the customs connected with circumcision rites. In more recent years much of this has changed. Traditional rites and customs may still be followed to some extent in the villages, but many people have flocked to the big cities. As a result these traditions are no longer taught and followed, there has been a great loss of respect for the importance of the family. This makes it all the more important that the parents teach their children by word and by example about family values. This is where the Bible places the responsibility. The relationships between husband and wife, parents and children are clearly set before us, in Scripture.
>
> If family values would be followed according to the Bible, we would have good marriages. According to our own family custom we were taught to have a high respect for marriage. When I was about 18 years old, in, grade 10 at school, a friend of my father came from his home village to instruct me about marriage, about having a family, and so on. According to our custom he did this, not my father. My marriage was arranged through the elders in the family. They also gave instruction about the importance of faithfulness in marriage. What I'm saying is that these things learned in the family through our parents and relatives were very important for living a decent married life. I sometimes wonder to what extent a custom like this is still followed.
>
> When the basic structure of the family is missing people will go the wrong way. Marriage is above all to be honored as God's sacred covenant between man and woman. When these two people promise faithfulness to each other, they must love each other, and they must also please each other. They must be willing to work for each other. The wife must take care of the household properly and also keep the home and the children in good order. Husband and wife must also be willing to make sacrifices for each other. They should work together and make plans for their children. The man should not go out alone to drink beer, or neglect his family. When it is a "marriage of convenience," just to have children, both husband and wife are in trouble. When there is trouble between them; they should talk to their relatives, especially their parents. They are the best ones to help settle problems.

Good family and marriage relationships are
the most important factors in protecting us from AIDS.

It was good to hear these things coming from someone here in Zambia: By putting his finger on the importance of family and marriage relationships, Sam placed the emphasis squarely on where it belonged. Where these two things are in order, AIDS is not going to be a great problem. What a beautifully positive way of putting it! When I asked Sam about the advice generally given pertaining to "safe sex" and "condoms," he replied that these things were only serving to encourage illicit sexual practices. "It has made people to use God's gifts wrongfully," he declared, "because they foolishly think that such things can make it safe." He appreciated that some of the things that were being taught in the schools were helpful in explaining the problem

of AIDS, but that it was more important that such things should be given a biblical background. Again, how good to hear this!

We discussed the matter of the church becoming more involved in teaching about the HIV/AIDS problem. He felt that this would be a good thing, especially if the fourth and sixth commandments would be emphasized, those that gave good instructions in family life and marriage. He mentioned Bible passages like Ephesians 6:1-4, and Ephesians 5:22-25, passages that emphasized the true relationship between parents and children, husbands and wives, and that these were the "most important things" in teaching about the way people should live.

He felt that the national church would appreciate it if nurses and missionaries would help prepare materials for teaching purposes pertaining to the AIDS problem, but that this should be done in conjunction with the national church.

We discussed how the introduction of a "sung liturgy" into our church services a few years ago was a joint undertaking, yet how it was the nationals who became interested in seeing to it that the work was continued. They were the chief agents in spreading it throughout the LCCA. The same procedure should be followed in teaching about AIDS, he suggested. "Let's work together on something like this," he declared. I gathered that he must have felt this wasn't always being done.

I greatly appreciated Sam's input. His family is an example of how some of the old African customs and traditions pertaining to family life and marriage can work together with biblical teachings, and also how the teachings of Scripture can now be the most important guide in showing Christians what God expects of his children. When children respect their elders, when fathers bring up their children in the nurture and admonition of the Lord, when husbands love their wives, even as Christ loved the church, and gave himself for it, there is hope for the prevention of HIV/AIDS. This was the beginning of a series of interviews that kept Kathie and me very, very busy over the coming weeks. We came first of all to listen and learn, not to try to teach.

THE WOMEN'S POINT OF VIEW

Kathie thought it would be a good idea to get the African women's point of view about the HIV/AIDS situation, so she met with Mrs. Kawiliza and Mrs. Hachibamba in a joint interview. I got the benefit of this visit via tape-recorder.

Mrs. Hachibamba, the wife of our seminary principal, has worked quite a few years as head of cleaning and maintenance at the Lusaka American School. Mrs. Kawiliza, Sam's wife, is secretary at our Lutheran Press on the seminary property. During our previous five-year stay here Kathie became closely acquainted with both women. Beginning with some questions of a general nature, Kathie elicited the following information:

> Most people in Zambia are well acquainted with AIDS, what it is, how it is contracted, how it spreads. The problem lies more with the men than the women.… Men are the chief offenders because they are not satisfied with one woman. They seek gratification of sex with others, even though they are aware of the dangers .... They forget about death as long as they can have pleasure, even forgetting about the children who are left behind if they die .... When they have the disease, they don't care about infecting others, as long as they can continue to satisfy their sexual pleasure.

Since this seemed to reflect to Kathie a rather poor treatment of women, she asked what they thought should be done about it. Was it a spiritual problem? How could the situation be changed? Who could help with this change? At this point the answers were slow in coming. After some prompting they agreed that all age groups needed help, but were rather vague as to how this could be done.

To approach directly those whom they suspected of having, HIV was to them extremely difficult, if not culturally almost impossible. Nobody with AIDS would want to admit to others that he or she actually had it. The very mention of it would frighten others away. There always seemed to be another excuse for being sick,

like “I’ve been drinking too much,” or “I must be having TB, or malaria.” The chief channel of helping such people was through the relatives. Both HIV and AIDS were “no-no” words in their society.

Since nobody wanted to admit that he or she had the disease, perhaps one way to help would be through the relatives, they said. One could inform the relatives about how to take care of the sick, and how important it was to eat the right foods to increase life continuance, etc. Again the answers were slow in coming, vague, and guarded. One was left with the impression that the problems connected with H1V/AIDS were serious indeed, almost so serious that the women hated to talk about it.

At a recent conference on AIDS at Yaounde, Cameroon, Dr. M. H. Merson told the gathering that “many African men have a natural dominion over women, a delusion of superiority that is similar in many ways to the delusion of superiority known as ‘racism’.” He added that “I see in these male attitudes the root of phenomena such as seeking younger women as sex partners, prostitution, and rape, all of which facilitate the spread of HIV.”

As for women and their “powerlessness” relative to men, Merson declared, “This (domineering attitude of men) makes it difficult for women to demand that their partner refrain from sexual encounters with other women. A mother, who is so financially dependent on a man, is the most vulnerable of all.”

Dr. Jonathan Mann, professor of health at Harvard and director of its International AIDS Center, told the Yaounde conference that “the role and status of women worldwide are fundamental to HIV prevention. The reform of laws governing property distribution and divorce may be more important in helping to prevent HIV infection than increasing the distribution of brochures or condoms” (From notes on the seventh annual African regional AIDS conference at Yaounde, Dec. 1995, by Jim Fisher-Thompson, USIA Staff Writer).

This reminds me of something I read recently about the AIDS dilemma as it applies to women in general. It refers to the situation in Latin America, the place where Missionary Jim Olsen and his wife Mary served whey they got into that discussion with Kathie and me at the breakfast table in Lima, Peru; leading to our further studies on AIDS intervention.

In an article entitled “The AIDS dilemma for Latin American women” (MAP INTERNATIONAL REPORT, Feb./March 1996 Vol. 20, No. l) Susan S. Weber writes, “In a culture dominated by a traditional machismo attitude and acceptance of male promiscuity, Latin American women are often powerless to protect themselves from the virus that causes AIDS .... In Latin America’s male-dominated culture, most men do not freely discuss sexual issues with their partners. In 80 percent of the HIV cases identified in Latin America the woman is in a monogamous relationship but evidence exists that the husband is sexually active in other relationships. The woman has no power to protest his sexual demands or to insist that protective measures be taken.”

AIDS, we are told, lies in the cultural status of the people troubled by the disease, particularly in the subjugated role of women in society. What we have heard here from some of the women in Zambia seems to agree. The cultural factor certainly deserves a closer look!

THE CULTURAL ASPECT

Before our coming to Zambia, son Ernie (Dr. E. R. Wendland) suggested in a letter, “We need to zero in more on the cultural aspect and try to identify where we are missing the boat in this respect. Most people here do know that AIDS is around and that it is fatal. They also know how it is transmitted. But why don’t they modify their behavior according to it? Is there some aspect of their worldview which discourages caution and moves them to take a chance with death every time they have sex with. a strange partner? Here are a few questions that you might ask your “informants” to elaborate on.

a. Does it have something to do with their general lack of concern for the future? People know that AIDS does not manifest itself right away, so why worry about an eventuality so far off and one that a person may not even experience?

b. How much does witchcraft play into the picture? If some people get it while others don't, does this mean that the unfortunate contractors of AIDS have been attacked by a sorcerer (or a witch), or that his/her protective charms were not potent enough to ward off such attacks?

c. Or perhaps there is even a more fatalistic explanation, namely that this plague has been sent by God himself (*cilango ca Mulungu*), or the ancestral spirits (*cilango ca makolo*) as punishment for some serious national or ethnic violation of the traditional norms and sanctions of the society? If this is so (thus rationalized), then the virus may be impossible to avoid anyway, so why change one's happy sexual way of life for what is in effect immutable?"

From my previous delving into the cultural life of the African (cf. *Of Other Gods and Other Spirits*, NPH 1978), I felt that there was a lot of truth in what Ernie pointed out. That also was evident now. Those whom I interviewed indicated by their remarks, although not always saying it in so many words, that there was this fatalistic attitude among the people in general. Like "We don't know what's going to happen in the future. We have so little control over it. Perhaps some enemy is 'witching' us. Perhaps we've done something to displease our ancestral spirits. We're going to die anyway. So let's get out of life what we can!"

Son Ernie did something more to open up the cultural aspect. He prepared the way for an interview with Pastor Salimo Hachibamba, one of my former students and now principal of the LCCA Lutheran Seminary. Salimo had also prepared himself in advance of my coming by approaching the subject from the cultural aspect. (The following, taken from a taped interview with Salimo, is almost verbatim.)

Salimo on the Cultural Aspect

"The underlying problem with AIDS really goes back to the tribal wars taking place in Zambia several hundred years ago. Many African tribes moved into this central region of the continent from other areas in search of more land for farming and grazing cattle. They fought against each other for control of the land. In these wars children were needed to be raised and trained as warriors. In order to have many children, many wives were needed. The wives were regarded as workers and childbearers, nothing more.

"After the wars were to a great extent over, the people settled down, but the practice of polygamy continued. Women were still needed to work in the gardens. A man's prestige and wealth were determined to a great extent by the number of wives he had. The woman became a slave and a childbearer. If she was unable to have children, she served no worthy purpose, traditionally and/or economically. This placed a lot of psychological pressure upon the woman. She suffered because of her low status. She longed for some kind of 'liberation,' not the kind you speak about in America, but liberation from her drudgery and low position in society.

"In this search for liberation there was really no place for her to appeal other than to the ancestral spirits. She needed to be 'possessed' in some way by these tribal spirits, something often achievable through tribal dancing. One might call it a rebellion, one in which through this possession by ancestral spirits she could attain a position somewhat higher than men. Through tribal rituals there was a way in which this 'spirit possession' could be achieved. As a result she often no longer wanted to sleep with her husband. She felt herself to be in a spiritual world, closer to the higher powers, more independent, more able to do as she waited. This led to the problem that the man went out to find other women in order to satisfy his sexual needs. This promiscuity, of course, contributed to the spread of AIDS.

"This attitude of 'woman-subservience' has continued to a great extent in society. Men are still very domineering. They feel that if a woman doesn't 'please' them, they have every right to go elsewhere for their sexual pleasure. One can see what this does to marriage and family life. The other problem connected with this is that mother and father frequently both die of AIDS, leaving their children behind. Who will take care of them? The boys become street-children. The daughters, left homeless, seek help through prostitution. Their offspring, in turn, born without any stable kind of family situation, live like animals. They continue to add to the problems of promiscuity. The whole situation gets out of control.

"Another factor is illiteracy. Street-children, homeless children, are to a great extent uneducated. They become sexually active around the age of twelve or thirteen. There is no way for them to learn about a proper attitude to sex-life. When they hear about the dangers of AIDS, say at age seventeen or eighteen, they are possibly already infected. When they realize this, they feel that they are already 'dead' for all practical purposes. So why not keep on with whatever way of life they have been accustomed to as long as they can? Spreading the disease further often means nothing to them.

"In our earlier African traditions children were taught about family life and sex at a much earlier age than nowadays. This happened through tribal rituals held in the villages. Nowadays, of course, these traditions have to a great extent fallen by the wayside, especially in the cities. In the cities the extended family system is also breaking down. There are too many children belonging neither to family nor tribe.

"The government can't begin to cope with these problems. Even by means of education, upon which people rely so much nowadays, there is not much that can be done. For one thing there are not nearly enough schools to take care of the children in the cities. Here in Avondale and Chelston only a small percentage of children can find places in government schools. Even those children who go to school are receiving their education by Western methods. The best way of teaching is like you and I are doing right now, face to face. Like the days when the grandfather would sit down and tell stories at a campfire in the evening.

"Just reading out of books and memorizing things doesn't work. Africans don't learn by reading alone. They remember what they are told, and need to be told this again. We ought to remember this in our church as well. We give our graduates from Bible school and seminary books. What happens? The other day, one of our pastors came to me and said that he wanted a Concordia Triglotta (This is a book of Lutheran Confessions consisting of hundreds of pages). I asked him what had happened to the one he had been given at our seminary. He said that the ants had eaten it! Perhaps it would be better if we would have more post-seminary teaching programs.

"Let's get our people together often and teach them the important things, again. Let's speak to each other more often. Then perhaps the books will do us more good.

"Western methods also predominate in our government schools. Drama, puppetry, methods with pictures, comics, and videos that are often used, are like watching soccer games. They watch, they laugh, they enjoy it, and then after learning about sex education and seeing it portrayed, they think that they ought to try it out, especially after being taught how to use condoms.

"Teaching here is not a game. According to our culture you sit down. You talk. You meet face to face. You discuss. In government schools where education in AIDS is so much relied on, you are often speaking to young people of the ages of seventeen and eighteen. They have already been sexually active. When you tell them about AIDS and its great dangers, you are often telling them that they are already 'dead.' They know that they may have done things through which they may have been infected. And so they conclude, 'If I am already dead, I may as well die with somebody else.' Perhaps it would be better if we would rather teach our young people that if they already have HIV, they can still have a purpose. They still need to help preventing Zambia from becoming destroyed. They must above all keep from infecting others.

"The only real answer is the church. We need to teach from God's word. We need to tell people that the greatest Healer is Jesus. He can give forgiveness and hope. The Bible can teach us how to live. I think we have often neglected this. I think that we as a church have often failed. We have not managed to apply God's word sufficiently to the lives of our people. Perhaps we ought to teach our future pastors more about purity of living in our pastoral theology courses at the seminary. Let them also teach the leaders in our congregations about these things from the Bible. Not just once. We Africans believe in repetition. Do it again and again, like I am doing right now, repeating myself, saying it over and over again."

The Follow-up with Salimo

In all this I just let Salimo talk, and I listened with my tape-recorder. Throughout his presentation he spoke from the heart, with great emphasis and evidence of concern. I continued by asking him a few questions

relating to culture which I had often wondered about. We hear a lot about the "cleansing ritual" in family tradition among tribes and families, whereby when a man dies, his brother must have intercourse with the surviving wife in order to "cleanse" her of his spirit. He answered that this is often overemphasized and misunderstood. Often the ceremony does not include actual sexual penetration, but is merely a sort of ritual like shaking hands. The sexual act does occur, he added, when it is followed up with the marriage of the two people involved. He also added that there is considerable difference in these rituals among the various tribes. In other words, we as foreigners often hear about African traditions and talk about these things, thinking we know all about them. But do we really understand them? Wouldn't it be better to let the people here tell us what they are all about?

I also asked about something that my son had referred to in his letter, namely that the Africans had "a general lack of concern for the future, certainly any event, good or bad, beyond a year away," and that this "might cause less concern about AIDS, since its effects might not manifest themselves for ten years or more." Salimo agreed that this could be a danger, but that such people ought to be taught to realize that if they continue in their careless way, the name of their family could no longer be carried on by one of their descendants. To preserve their name would be something very important to them, and would perhaps make them think twice about throwing it carelessly away through the death of their children.

We also talked about traditional healers, sometimes referred to as "witch doctors," and what their effect would be in this problem. Many of them claimed to be able to heal people who are suffering from AIDS. Salimo said that even though they could not actually heal them, they could perhaps in their role as "traditional healers" ease some of the suffering of those afflicted with AIDS through herbal medicines. He referred to Dr. Luo, a professor at UTH, who was able to speak to traditional healers and warn them to take more care with sterilizing their razor blades when cutting tattoos in the process of applying their medicines. "The *singanga* (traditional healer)," Salimo said, "can at least persuade people who have been infected with AIDS that they through proper foods and medicines can continue to live for a few years more, that they are not necessarily already "dead," and can continue to serve a useful purpose." He told about family members and friends visiting their sick friends at UTH with bottles of *mankwala* (medicine), to "assist" the medical doctors with their AIDS patients.

In his closing remarks. Salimo emphasized the need to have a continuous teaching program about HIV/AIDS. He stressed that the whole program should be organized through Bible studies, teaching programs, youth clubs, district gatherings, and so on. He mentioned the teaching programs at Mwembezhi, where leaders could be trained with the assistance of Clinical Officer Alfred Mkandawire, community workers who could be sent out to the villages, as well as to the congregations in the various districts and parishes of our entire church body. We discussed the Primary Health Programme which had been organized so successfully at Mwembezhi, and agreed that this kind of system would be a good model to follow.

Somehow I felt greatly encouraged by my dialog with Salimo. Certain avenues seemed to be opening up. Perhaps the tunnel of fear and gloom had a path, after all, that could be followed. Perhaps there was a way to get to the people, a way which would fit in more with their culture and traditions. Perhaps our work at Mwembezhi could supply some of the answers.

I was ready, more than ready, to explore these possibilities further.

A NATIONAL PASTOR SPEAKS

We've seen how both LCCA Chairman Kawiliza and Seminary Principal Hachibamba have given their views on the subject of AIDS. Both interviews, as well as the conversation between Kathie and their wives, were very helpful. Things were beginning to take shape, both as to the great need as well as the direction in which our help might be most effective. But what was the situation like in one of our established LCCA urban congregations? The congregation which first came to mind was the one in Matero, where our early missionaries started in an urban compound just outside of Lusaka. This was way back in the 1950s. In later years I had helped there off and on, learning more about what it meant to serve in an urban situation. At the present time the congregation was being served by Pastor Mpofu, a recent graduate of our Lutheran Seminary in Chelston.

I knew Pastor Mpofu from his student days at our Bible institute and seminary. He had been a very conscientious student, and I was happy to hear that he was being well accepted by the people of our Matero congregation. We had had our congregational ups and downs in Matero, and I was happy to hear that things there were going well.

I began again by letting Pastor Mpofu talk about anything he had in mind about the AIDS situation. This is a resume of his chief thoughts in the order in which he related them:

> The problem is serious, very serious. We in our congregation are trying to deal with it through teaching our people about the family and marriage, and the Sixth Commandment whenever we meet. We have Bible Class for all people on Sunday morning, youth meetings in the afternoon, and meetings with the women on Thursday afternoon .... But we need more materials in order to do a better job. . . I think this is very necessary because within the past few months I have had twelve funerals resulting from AIDS or sicknesses coming from HIV. Sometimes I think that there is a funeral nearly every week because of AIDS . . . . We have a large number of street-kids in Matero. These children are living without fathers and mothers. Sometimes some of our church members take them into their homes out of pity for their situation .... When I know about people suffering from AIDS, I visit them almost daily.

When I heard this, I asked him how he knew that these people he visited had AIDS, since from previous conversations I had heard that this word is seldom used among the people, and that it was difficult to know whether they actually had it or not. He simply replied, “They know.”

I asked if his words of comfort from the Bible helped. He said that these words of comfort meant very much to them. He was interested in organizing a workshop with Joanne Halter, and that she had also offered to help him with some materials in connection with the AIDS problem. This led me to ask if he had any ideas as to how the church could become more involved in addressing the problem. He seemed to be waiting for this. He immediately replied that we ought to be training leaders, people from the church, people from other churches, leaders within their congregations, who could come together for “short courses” and be taught how to help deal with this problem.

As to organization, he said that in the LCCA we had various districts - Lusaka, Mwembezhi, Choma, Copperbelt, Northwest Province, Chipata - areas which could be organized in some way that training programs should be held for them.

As to materials, he agreed that Zambians should be involved in their preparation, but that help would be needed at first in getting such courses started. Since he had been involved in helping get our liturgy program underway in our congregations, I asked if a similar type of method would be the way to proceed. “Yes, very much so,” he said.

I couldn’t get over the way in which the people in our various interviews coincided in their thinking. The question arose in my mind as to whether we were guiding the people we were interviewing, or if they were guiding us. The problem was serious. More than AIDS was at stake. The family, the home, marriage, love and concern for others, relating Christianity to the lives of our people, pastoral care, all these things were a part of the problem.

Whatever was to be done would have to happen in partnership, and on an organized basis. In order to do this we needed to get the people here involved. The work would have to be done through them, on a continuous basis.

Has the problem of AIDS been opening my own eyes more to the fact that, we as a church need to be engaged more and more in relating the doctrinal aspects of Christianity to the practical aspects of Christian living? Where is God leading us in all this? It seems to be taking me, at least, much farther than I first realized.

I only hope that I am not the one leading these people in what to say, but that their ideas and expressions of opinion are coming directly from themselves, and that what we finally come up with is mutually resolved.

Where are we going, Lord? Help us find the right answer!

ANOTHER RAY OF LIGHT IN THE TUNNEL

My next interview was with Sylvia Gustavison, the present nurse-administrator of our Mwembezhi Lutheran Rural Health Centre on the Sala Reserve, about 50 miles west of Lusaka. This was the medical mission in which the women of our congregations in America became involved in the late 1950s, and are still very active today.

It may be well to go back a bit in the history of this mission. This history, I believe, bears repeating. Our humanitarian interests at Mwembezhi go back to the first missionaries who went there in 1954. The people from that area came to them, pleading for help with their health problems. When these pleas became more and more urgent, a rural health clinic was established there in 1961, largely through the investigative studies and direction of Pastor Edgar Hoenecke and his wife Meta. A medical committee was appointed, guidelines for the work were determined, and a medical mission program was set in motion.

This health project has been in operation there at Mwembezhi ever since. Nursing sisters have been sent from America, working at the health clinic together with a national staff supported by the Zambian government. At first the chief attention of the work was directed toward the care of those suffering with malaria, diarrhea, dysentery, pneumonia, and other ailments. The work expanded into immunization programs, helping with malnutrition, and with the care of mothers and children.

Another step was taken toward the direction of primary health care, organizing and training community workers and traditional birth attendants from the surrounding villages. The clinic continues to see 25,000 to 30,000 patients annually, and manages 75% of the community health workers and traditional birth attendants in the Mumbwa district of Zambia. Financial support from the women of our synod comes to about $150,000 annually.

Sylvia Gustavison, RN, BSN, now serves at the clinic with Alfred Mkandawire, a Clinical Officer, who has been with us since we began in 1961. Other Zambians have been added to the staff, including enrolled nurses and dressers, a midwife, and an environmental health officer. All but one of the present eight on the national staff are members of our Lutheran church.

Our Mwembezhi Rural Health Centre has gained a good reputation. Through it the name “Lutheran” has become well known as a rural agency having a concern for the people of Zambia, also to many outsiders in the Lusaka area. When the Zambian government’s Ministry of Health inaugurated its Strategic Health Plan under the Zambia National AIDS/STD/TB and Leprosy Programme (ZNASTL), our center was one of the first places in Zambia to hold a rural workshop.

I asked Sylvia how we managed to get into this situation so quickly. She replied that she had noticed people coming to our clinic looking, as she described it, “very drawn, suffering from weight loss, and looking frightened.” They were chiefly “young men.” “Something was really wrong here,” she added. She inquired further, and found out about the government’s ZNASTL Programme, leading to her submission of a “proposal” for holding an AIDS workshop at Mwembezhi, to be funded by NORAD, a Norwegian government health assistance organization.

The six-week workshop on AIDS counseling was held between January 15 and March 12, 1996 at our Mwembezhi Rural Health Centre, attended by our WELS Mission Coordinator Missionary Stephen Lawrenz, Mwembezhi Missionary Philip Birner, clinical staff persons, area school teachers, traditional birth attendants, and community health workers. Sylvia and Alfred were in charge locally. Presenters from the Chainama Hills Hospital were contacted, and the following three served as workshop presenters: Pascal Kwapa, CO, Martha Chilufya, ZRN, and Chimutalanje Lenje, M.D. All three were experienced in HIV/AIDS counseling. As an extra bonus a part-time presenter was Catherine Rosensvard, a psychologist from Sweden.

The purpose of the workshop was to give information about the basic facts of HIV/AIDS, about methods of counseling people who needed testing for the HIV virus, how to talk to these people about their condition, and giving advice about lifestyle and behavior from a Christian viewpoint. The eventual goal was to persuade those who were counseled to give consent to a screening program leading to definitive testing carried out in

conjunction with the Lusaka UTH hospital. Many other items relating to the AIDS program were presented and discussed.

This was followed by a seven-week "practicum," during which those in attendance visited potential AIDS patients, counseling them according to the instructions that had been received at the workshop. The counselors were requested to make out a report of their experiences, to be presented and discussed at a follow-up meeting with the presenters.

After the seven-week "practicum" the workshop met for its final week, at which the participants presented their reports for discussion and critique. Sylvia reports that "Rev. Birner and Rev. Lawrenz enriched the sessions from a spiritual and Christian framework with their comments and contributions." The last day was spent going over the test results and written case histories. Certificates were presented to the participants. Sylvia summarized, "It was a good workshop. Many expressed the belief that the learning process had only just begun."

The test results were quite revealing. Only five out of the 135 patients whose symptoms or sexual behavior indicated that they were at High risk for AIDS refused to be tested. Of those tested 66 % came back positive, equally divided between men and women. The percent of those tested exceeded by far the results of similar programs held in the Lusaka area. Another interesting item is that the preliminary tests taken at Mwembezhi were 100% substantiated by the laboratory ELISA test made at the UTH hospital.

This was the sum and substance of my interview with Sylvia. I'm afraid it's a rather limited, unprofessional resume of the more extensive report made out by Sylvia, which gives complete details and would be especially valuable to anyone who contemplated taking on a similar kind of program. (I hope Sylvia's report can be included as an addendum).

I asked Sylvia about Chikankata, a medical mission in Zambia's Southern Province conducted by the Salvation Army church. This mission has quite a good reputation in connection with its work in HIV/AIDS intervention, and I at one time had plans for a visit there if at all possible. Sylvia said that Gertrude, one of the nurses at our own clinic, had attended classes there in AIDS counseling, and reported that the workshop held at Mwembezhi was basically the same as that held at Chikankata.

Our interview was concluded with a discussion of how this kind of program, held at Mwembezhi, might be shared with other congregations and areas in the LCCA. There have been questions from time to time as to why Mwembezhi is so "medically favored," while other places in the LCCA are not enjoying these benefits. We ended up this discussion with more questions, perhaps, than answers. Whether or not Mwembezhi can somehow serve as a sort of teaching center, serving the LCCA at large, certainly deserves further consideration.

I'm personally thankful that through these efforts at Mwembezhi an important step has been taken toward seeing how it is possible for many people to be served through a very important AIDS counseling method. Can this be strengthened? Can it be shared?

Perhaps more light, we pray, has entered the tunnel of the HIV/AIDS problem. May the Lord show us the way!

THE END OF THE TUNNEL?

From the very beginning of our trip to Zambia, Kathie and I had hoped that we would be able to get to Mwembezhi some time during our stay. With Kathie working daily at the embassy, and me teaching daily at the seminary, a visit of this kind would have to be worked in over some weekend.

This opportunity came on Sunday, June 23. We packed a lunch and left right after the church service in Lusaka. Pastor Theodore Sauer, who had arrived a week previously from America and was staying with Kathie and me for the rest of our stay, accompanied us. Pastor Sauer, former executive secretary of our synod's Board for World Missions, had served as superintendent of the LCCA and also as resident missionary out at Mwembezhi with his wife Althea for over seven years.. For him the visit was especially memorable.

Also along for this trip was Mr. Thomas Tauras, international director of Project Concern (PCI), with whom Kathie and I had become acquainted in Lusaka. Tom, here on a visit from San Diego to attend a Project

Design Workshop on HIV/AIDS, was well acquainted with Dr. Heinz Hoenecke. He thought it would be interesting to see the dispensary project in which Heinz's father had played such a prominent role.

A few days before this visit I had been able to schedule an interview with Alfred Mkandawire, the clinical officer out at Mwembezhi with whom I was well acquainted. I think we've mentioned before that Alfred "came with the place." When starting the clinic in 1961, Mrs. Hoenecke hired Alfred as one of its first dressers. During his continuing years of service he kept on learning and studying, attaining the rank of Clinical Officer. His work is highly regarded by the people in the surrounding area.

Alfred has served us well. At the clinic he plays a leading role in diagnosing and treating the ailments of the many who come to us. He has played an important role in our primary health program at Mwembezhi. He can speak to the people in their own languages. Before undertaking the AIDS workshop referred to in the previous chapter, he held a meeting with all the headmen in the area, urging their cooperation. Not only the headmen of 29 villages came, but many others as well. When I questioned him about this meeting, he mentioned that he had placed a spiritual emphasis on his lecture. He told the people about God's warnings concerning bad sexual behavior, about God's purposes in marriage and family. When I asked him from where he got his material about all this, he gave me a quizzical look and simply answered, "From the Bible." Alfred is a member of our Mwembezhi Lutheran congregation, also serving on various boards and committees of the LCCA.

Most of my private discussion with Alfred had to do with the AIDS workshop referred to in the previous chapter. He was very positive about its purpose and its need for the community. When I asked him if there was anything else he might want to discuss, he asked me about the health classes at the Lutheran Seminary. I was glad to hear this coming directly from him. I'm sure that he can serve a very worthwhile purpose in this capacity, and intend to mention this to Principal Hachibamba.

While on our visit to Mwembezhi we were pleased to see everything looking so orderly, quite proud, in fact, to show it to our distinguished visitor. This speaks well also of Mr. and Mrs. Gerald Schulte, our "Kingdom Worker Family" on the Mwembezhi property, with whom we also visited while there. The Schultes make good homemade ice cream! We had our noon luncheon at the nurses' living quarters with Joanne Halter, presently serving there in connection with our AIDS research, as mentioned in the introduction. The place looks good, and brought back many memories for Pastor Sauer, Kathie, and myself.

While at the dispensary Alfred showed us the lists of community health workers and traditional birth attendants, prominently listed on a wall chart in the entryway of the dispensary. It is a real pleasure to see so many from the community involved in our Mwembezhi programs. The thought can't escape one that Mwembezhi could possibly serve as a center for the entire Lutheran Church of Central Africa in connection with the HIV/AIDS program, as well as for health matters in general. Couldn't congregational leaders from various parts of Zambia be brought to Mwembezhi for HIV/AIDS workshops? Couldn't health counselors be taught and trained here, using our experienced medical staff and the facilities located there in a continuous type of program?

Aren't we perhaps sitting right on top of a possible solution to a distressing problem, one affecting the people of our congregations as well as the people of the area? Is this an impossible dream? To be sure, much discussion, much planning must take place before a dream of this kind can became a blessed reality. With the Lord on, our side, we've already seen dreams about the work in Africa become realities!

"One of you routs a thousand," Joshua told the people of Israel, "because the LORD your God fights for you, just as he promised. So be very careful to loge the LORD your God" (Jos 23: 10-11).

AN UNEXPECTED BONANZA

Fortuitous? Serendipitous? Divine intervention? Things seemed to be falling into our laps in an almost eerie, fairy-tale way! Both Kathie and I were suddenly invited to participate in an HIV/AIDS workshop sponsored by the United States Agency for International Development (USAID), in which leaders in AIDS intervention from Zambia and abroad were participating.

The HIV/AIDS Collaborative Project Design Workshop was scheduled to meet on the last two weekends in June. Dr. Heinz Hoenecke had mentioned something to us about this prior to our leaving the U.S., and Kathie had been hearing more about this through her work at the U.S. embassy, but we had no idea that we would be invited to participate. A few days before the workshop was to begin, we received an invitation from Mr. Paul Hartenberger, USAID Director of the Population Health Nutrition Office in Lusaka. In his letter Mr. Hartenberger mentioned that the workshop's core design team would consist of USAID staffers from Washington D.C., external consultants, UNAIDS and USAID/Zambia staffers, and that it would be a "collaborative design model, involving a host of colleagues from the Ministry of Health/GRZ, NGOs, private health representatives, and bilateral donors." Quite an impressive array!

Kathie and I had previously made plans to spend the coming weekend at the Cutty Sark Resort on the shores of Lake Kariba, but this invitation took precedence. In addition to Mr. Hartenberger's letter a telephone message came from the USAID office encouraging me to attend. Apparently a certain Mr. Thomas J. Tauras, International Director of Project Concern, had received a message from a. certain "Dr. Heinz Hoeneck (sic)," President of Pathologists Overseas, that an "influential man in the Lutheran church and very knowledgeable on HIV issues" should be a part of the workshop. How could we refuse?

So there we were, at the Intercontinental Hotel, on Friday, June 21, ready to participate. The workshop was opened by Dr. Joseph F. Stepanek, USAID Director in Zambia, who introduced Dr. Moses Sichone, the National AIDS Manager of the Zambia Ministry of Health. After reviewing the history of AIDS intervention efforts in Zambia, Dr. Sichone emphasized the need for new studies in order to "identify and prioritize the major opportunities and gaps in HIV/AIDS programming," and to "improve public, private and donor coordination toward making the best contributions to AIDS programming in Zambia." This pretty well summarized the objectives of the workshop. His words strongly indicated that a better identification of problem areas and an improved collaboration of the agencies involved were needed to obtain better and more efficient results.

USAID Design Team Leader, Dr. Paul Deland, explained the "design team" concept. Participants were to form groups of five to six people, each group gathering around a table for the propose of working together to identify the primary areas of HIV/AIDS prevention and care activities. (Five tables, were organized and five primary areas were identified.) Participants then were to choose the area in which they were primarily interested. They were to identify the "opportunities" as well as the "gaps" of that area, and also recommend ways of dealing with the "gaps." This procedure occupied most of the first weekend.

On June 28 the workshop continued. In the meantime the design team had studied the results of the first sessions and had narrowed the areas to four key segments in need of further attention. These involved.: 1. Counseling and testing / 2. Utilization of community resources / 3. Behavior and education / 4. Collaboration between government policies and agencies. (The design teams may question with my designations of key areas here, since my own choice of terms may not always agree with their more professional terminology.) These key areas were again placed into the hands of teams for further discussion, identification, and definition. Each team gave a final report of its findings through its leader.

The workshop was brought to a close by Mr. Hartenberger, who thanked the design teams and participants, and spoke of some of the problems involved in budgeting and processing any further funding by USAID. Since the U.S. government is generally cutting back in its allotments toward foreign aid programs, some reductions might be necessary, he explained. He did urge all those interested in funding, however, not to be discouraged, but to make their proposals as soon as possible in order to be in time for budgetary decisions coming up soon. A summary report by the design team will follow, we were told.

Some impressions? I thought that the workshop was well designed and well carried out. I told Dr. Deland that this was my first experience with this kind of "design," but thought it was effective in eliciting opinions from those directly involved in existing programs, also getting at first hand their own suggestions for improvement without handing this from the top down. I think this is one of the problems we Americans are guilty of, proceeding with our American ways without finding out first from the nationals what best fits into their culture and situation. I feel that the workshop certainly highlighted areas which in their opinion needed

special attention. A greater emphasis on community participation was needed. More efficient cooperation between government and non-government agencies was desired. Counseling and testing needed improvement. Education efforts did not seem to be leading into better behavior. Reliance upon condoms as an answer to the problem of sexual behavior was seriously questioned.

For Kathie and me the workshop offered an excellent opportunity to meet key people from various organizations and agencies, both in Zambia and abroad, and to exchange ideas with them. I'm thinking especially of a man like Roy Mwila, Project Coordinator of Care International, who is working in Mtendere, Lusaka, working at identifying orphans and helping take care of their needs within their existing extended family structures; like Pascal Kwapa, Coordinator of the Zambia AIDS Program Counseling Services, who did such a great job in leading the counseling teaching team out at Mwembezhi; like Tina Chonde, Head of Fatima House Based Care in Kaunda Square, Lusaka, a specialist in counseling those afflicted with AIDS; like Samba Muvuma, CO with the Government Ministry of Health, who works with traditional healers and would certainly be able to give advice about their efficiency; with representatives of Kara Counseling and Hope House in Lusaka, non-governmental agencies (NGOs) that specialize in counseling and care of AIDS patients.

I'm flunking of what a pleasure it was to get to know the design team, especially Susan Hunter, in whose team I was involved, Ben Harris of WHO, formerly of Liberia and Malawi, who told us about the sad situation in those places. I'm also grateful for having had the opportunity of getting acquainted with Thomas J. Tauras, Director of Project Concern International, who accompanied us to Mwembezhi and will make further contact with Dr. Heinz Hoenecke. I sat with him during most of the workshop and was able to exchange ideas. I'm thinking finally of the organizers and leaders of the workshop already mentioned in this report, who went out of their way to make Kathie and me feel welcome. It was a great experience.

There were, of course, a few glitches. As we assembled for the first session I was sitting by coincidence at the same table with Sanjay R. Chaganti, Director of Contraceptive Social Marketing, who gave his salespitch immediately on the importance of condom distribution. When I took issue with him on this, he spoke at some length on how careful he was to show how abstinence was "the better way", yet how condoms were still needed as "a last resort." Strange, isn't it, how nearly half of the millions of USAID dollars are going toward the distribution of condoms!

I'm not disputing that somewhere along the line condoms may have some value, but by addressing the underlying promiscuity problems connected with AIDS through increasing the sale of condoms implies that this kind of lifestyle can be carried on without consequences. Actually it is a well known fact that teenagers and married men are encouraged thereby to participate in extramarital affairs, and that they are led to believe they can do this without the danger of physical and emotional damage. I noticed how in later team assemblies Mr. Changati managed to stay away from my table as far as possible.

Both Kathie and I feel that in both teaching and counseling there is a danger in presuming that our Western methods can supply the answer without first finding out what works most effectively in the Zambian culture. The same applies to teaching and learning in general, as I've had to find out, sometimes the hard way. This workshop, we believe, showed special care in getting the opinions of the Africans who had been personally involved in AIDS prevention and care for the past number of years. Their opinions were sought and taken into consideration into the discussions. At times I felt that some of the expatriates present could have talked less.

One thing that pleased me especially about the workshop was its emphasis on community and also church activities in the promotion of HIV/AIDS prevention and care. This agreed very much with what we were doing out at Mwembezhi with out workshops under Zambia's Strategic Health Plan, training community workers in helping with counseling and testing programs, an activity which I feel should be made available to other parts of our church and the country. This not only fits in by making use of the most effective methods of HIV/AIDS prevention and care found so far, but we can add the all-essential ingredient, the word of God.

I'm convinced that we have what is needed; I hope and pray that we can make use of it effectively!

A BRIEF INTERLUDE

Following the HIV/AIDS Project Design Workshop, Kathie and I spent a week in Malawi. We visited son Mark and his wife Louise and family in Blantyre, also hoping to find out what was happening in that neighboring country with the AIDS situation. A succession of concurrent holidays made it possible for both of us to have this break in our schedules.

Before leaving via Malawi Airways on Sunday, June 30, we took time to attend morning church services at Good Shepherd Lutheran Church in Lusaka. As I sat there in church, I recalled how our mission had started in Lusaka over 40 years ago. First the little flock met in the missionary's dwelling. After a few years, a church had been built at the very place where I was worshiping that Sunday morning. The original building had been enlarged to accommodate later growth.

What a remarkable difference in the makeup of the congregation between those early years and now! From the few family members of missionaries and a scattering of expatriates from Europe, the attendance was now made up primarily of people from Zambia, Malawi, Tanzania, and other countries in Africa. A guest choir from the Mondevu compound in Lusaka sang for the service. The place was jammed and filled with praise.

The preacher was Pastor Salimo Hachibamba. His sermon was based on the day's epistle selection, Romans 5:6-11. I've never heard a better exposition of the doctrine of justification, how God declared a world of sinners reconciled through the death of his Son, our Lord Jesus Christ. The precious gospel was being proclaimed in Lusaka by one of our own seminary graduates, now principal of the Lutheran Seminary and co-pastor of this congregation. His presentation of the sermon was followed with rapt attention. Salimo has a different way of preaching, more repetitive, more text expository, and they listen! One sees and hears something like this and has to say in the words of Balaam, "See what God has done!" (Numbers 23:23)

And the choir? I mentioned to Kathie later how much one would like to take a group of young people like this to America to sing in some of our congregations there. She had had the very same thought. Incomparable voices, perfect precision, rhythmic interpretation, above all every singer giving full attention to the talented director, all with typical African enthusiasm. An unforgettable experience. As we mentioned in our centennial history of WELS world missions, "Blessings Beyond Expectations." One can't participate in something like this without being strengthened in the conviction that the LORD keeps all his promises. The Lutheran church has been planted in central Africa to stay!

As Kathie and I flew over the countryside from Zambia to Malawi, we were reminded of the days when we lived here. The patches of raw, red soil, interspersed with green umbrella trees, gigantic pillars of cumulous clouds against a deep blue background, a rosy sunset which suddenly disappeared with the sun over the horizon, leaving a purple afterglow spreading over the western sky! Both Zambia and Malawi are so colorful in their natural beauty!

As we landed at the Blantyre air terminal, a pall of darkness had already covered the earth. Darkness comes quickly in central Africa. Was this a premonition of a gloom cast over the land because of the threat of a certain disease? How serious was this threat? What would Malawi bring? We had come to find out.

THE MALAWI CONNECTION

Our WELS mission had begun in Zambia (formerly Northern Rhodesia) in the 1950s. The decision was made in 1964 to expand the work to Malawi (formerly Nyasaland), with the Richard Mueller and Raymond Cox families transferring to the Blantyre-Limbe area. The move was made in the year of Malawi's independence. Without going into a lot of detail, it should be mentioned that the gospel work has spread even faster in Malawi than in Zambia. Mark tells me that we cannot begin to keep up with the requests for the gospel that are coming constantly. Missionary John Janosek, resident with his wife Yvonne for over 30 years and presently coordinator of the work, is still on the forefront in following up these requests. Missionaries come and go, but John keeps on going!

The medical mission which had begun its work to address the health needs of the people in Zambia, had also started work in Malawi in 1970, as a mobile clinic. Located at first on the shores of Lake Malawi, later moving to Lilongwe, the focus has always been on preventative medicine. We have been aware as well of

seeing the "opportunity to do good to all people, especially to those who belong to the family of believers" (Galatians. 6:10). Is the AIDS crisis another opportunity to show the unrestricted love of God in a concrete way to all people? Can we utilize the Lutheran Mobile Clinic, which is now well established, to assist those who belong to the 20,000 member family of believers in our Lutheran Church of Central Africa in Malawi?

Mission work, as we know, depends on where the people are. The Apostle Paul went to the big cities. No doubt other apostles worked in rural areas. We accommodate to the need. In Zambia this has been largely in urban centers, not ignoring, of course, some fruitful rural areas. In Malawi the work, on the other hand, had been more in the rural areas than in urban centers. As many as 85% of Malawians live there.

While spending the week with son Mark and Louise and family, Kathie and I were able to drive through the hilly countryside surrounding Blantyre. Again we were able to see that Malawi's population is far more dense than in Zambia. Wherever one goes, the roads and markets are thronged with people. One might add that the population is definitely more pedestrian than vehicular. I've often wondered how people can possibly transport so much by simply carrying it on bicycles, or even on their heads!

During the week of our stay Mark and John Janosek held their regular meetings with the pastors and other workers in their area, discussing sermon materials, Sunday School lessons, and other matters relating to their work. I saw some of my former seminary students, now pastors in charge of large parish unions. I was able to explain to them briefly my interest in the HIV/AIDS problem, inviting their comments.

Their reaction was pretty much the same as that of the Malawi students I had just been teaching in Zambia. They all agreed that the disease was a problem, a huge problem, but seemed rather reluctant to say much about it in an open meeting: I mentioned that they would have more opportunity to find out more about AIDS in the following week at their pastoral conference, when Joanne Halter from America would be speaking to them on the subject in connection with advice on counseling.

I did get to sound out the pastors a bit more during a recess period, and found that they felt more free to speak about it individually. Pastor Kissinger Lusio (he says he chose the name Kissinger because he liked the former US Secretary of State), who serves several large congregations in the Thyolo district, spoke of the sudden increase in funerals in his area. When I asked him what he thought was the reason for this, he simply replied, "The people are so poor. Many are starving. The young women seek money for food, and sleep with others to get it."

Pastor Boloweza, the man spearheading our outreach into Mozambique seemed especially interested in finding out more about the problem. Both of these pastors also indicated that if they would confront someone about possibly being HIV+, the individual would "run away" or "hate you." They thought it best to minister to them individually with word and sacrament and strengthen them with the hope that only the gospel of Christ could bring. They did feel, however, that there was a need for more information in order to better cope with this growing problem.

New Sources of Information

After speaking to Mark and Louise about our interests in the HIV/AIDS situation, Louise motioned that she had some contacts in Blantyre which she thought might be sources of information. As a matter of fact, these sources turned out to be, as the British say, "superb," dealing with the three main areas: counseling; care, and prevention.

AIDS Counseling at Queen Elizabeth Hospital, Blantyre

Louise introduced us to Trevor Mackriell, Assistant Pastor and AIDS Programme Leader at the Blantyre Christian Centre. This is a non-denominational agency, supported by interested people in the area. The AIDS counseling program order Mackriell's direction is centered at the Queen Elizabeth Hospital, and is supported in part by a grant from USAID. Pastor Mackriell mentioned that USAID will unfortunately not support any program without condom distribution as a main focus of the written proposal which is submitted to them. For

our interview, conducted at the Christian Centre, he introduced Kathie and me to two Malawians, George Kukhaca and James Chirwa, the two who were responsible for the work at the hospital. They explained to us how they carried on their program.

They received their information concerning those in need of HIV counseling directly from the doctors at the hospital, as they were caring for people suffering from diseases they suspected of being HIV related. One of their first steps in pre-counseling was to establish a friendly relationship with these patients. Their eventual purpose was to encourage testing for HIV by the doctor. In order to do so, however, they had to assure the patient first of all that mere testing did not necessarily mean instant death, as many seemed to fear. Even if this test turned out to be positive, it would be better to know this for the sake of protecting others, as well as to learn better how to continue a productive life. This also gave them an opportunity for Christian witnessing wherever possible. Both George and James are Christians. Both felt it would be very beneficial to have someone working with them to address the medical questions which arise.

They mentioned that 95% of those whom they persuaded to be tested turn out to be HIV+. These are then followed up with hospital visits for Christian counseling, visits which extend also to the other members of the family and into the village where they live. Here they also arrange general health talks for the village in conjunction with a nursing sister, they are not singling out and openly labeling HIV+ individuals. It seems that here in Malawi, as in Zambia, the stigma of admitting to being HIV+ means isolation, rejection, possible abuse and divorce for a woman, and a long, lonely death.

It was interesting to observe that Pastor Mackriell said very little during our interview. His background is engineering. He sees himself as a facilitator to help for the Malawians to do the counseling. He entrusts this counseling to George and James, since as Malawians, they do a much better job of it. Both of them have been working with Pastor Mackriell on this project for over three years. Others have begun to be counselors, but have dropped out of the program. These two do their work individually, but meet together after each day of hospital visits to discuss their cases and to encourage one another. One had to admire the obvious dedication with which George and James spoke of their difficult, often trying and depressing work. One reason which helped them continue was a daily conversation together, through which they could encourage one another with God's Word.

"The demand is great," Mackriell said, "and we expect to expand."

AIDS Care—At Open Arms Infant Home

From "AIDS counseling" we switch to "AIDS care." This involves especially the person of Davona Church, the founder and director of Open Arms Infant Home in Blantyre, who was also introduced to us by Louise. There are similar Open Arms houses in the UK and in the US, apparently sponsored by the Seventh Day Adventist Church in Berrien Springs, Michigan. The address of the Blantyre home is Box 951, Blantyre, Malawi.

The Blantyre home was established in 1995 as a personal undertaking of Davona, a mother of six, four of whom are adopted. She is assisted by volunteers and a staff of Malawian "nannies," who, are assigned to individual babies as "mothers." The "Home" in Blantyre is a rented residence with a capacity of 25 babies, who are referred to it by hospitals, churches, and social welfare agencies. Any infant whose mother has died for any reason, and where the family is unable to care for the baby, may be referred to Davona for care.

Within a few months 60% of the babies received in the home die of AIDS. Surviving babies are returned to their relatives or placed in a foster home or adoptive family. They are currently planning to hire a Malawian social worker, who they hope has solid qualifications, to assess and advise families on the best way to care for the babies. Support comes from sponsors, individuals, or interested groups, such as schoolchildren. All who are interested in "helping babies", both local and overseas, are solicited. All formula is donated by the Nestle company of South Africa, and all soap products are donated by a local chemical company.

From the home's publicity brochure we quote a few excerpts: "The Central African country of Malawi is one of the poorest in the world, it also has one of the highest rates of AIDS (35% of people of child bearing age, 10% of the total population, similar to Zambia) . . . .Until the AIDS epidemic, orphaned children were embraced

into the extended family, but with AIDS claiming so many income earners' lives, it has weakened the family structure . . . .There are over 500,000 orphans in Malawi, and the numbers are increasing. Coping with this problem is an awesome task for any Government, but particularly one as poor as Malawi .... Pregnancy accelerates AIDS, so many mothers die shortly after giving birth, leaving newborns with no one to feed and care for them. Many of these babies are born testing positive for HIV. About half are only carriers of the mother's antibodies, and do not actually have the virus. Those babies who are fortunate to be free of the virus, are often malnourished and ill-equipped to fight common illnesses . . . .That's where Open Arms Infant Home fills a need."

(More detailed information about Open Arms Infant Home is contained in an illustrated pamphlet by Hilary Abraham, entitled "Open Hearts and Hands for the Open Arms.")

AIDS Prevention, ADRA

Davona Church also referred us to her husband, Max Church, in charge of the Adventist Development and Relief Agency (ADRA), and also to Michael B. Usi, a Malawian, the Project Manager in ADRA, who directs their AIDS prevention program. The program is partially funded by DANIDA, a Danish aid agency, which also requires condom distribution as part of the requirement for approval when submitting a proposal to obtain funding.

Both Church and Usi explained how the Adventist Church is cooperating in this endeavor with the Churches Hospital Association of Malawi (CHAM), serving 50 medical clinics in the Southern Region of Malawi, a catchment area of 600,000 people. The Adventists themselves have sixteen rural clinics in the Southern Region, three clinics in Blantyre, and one in Lilongwe. Michael Usi supervises all 50 clinics. Each clinic has a paid representative, who has been specially trained as a "community health worker" by the ADRA project and reports to Usi frequently. Each of these "community health workers" heads 15 trained volunteers from the Surrounding, villages who have been chosen by the leaders of the area.

Michael explained how the program he managed involved AIDS prevention, not counseling and care. It began five years ago with informational outreach to the villages, explaining the HIV/AIDS dangers by means of meetings of various age groups, using various teaching methods of making the people aware of the dangers of the disease. It seems that this effort alone was not sufficient to produce behavior changes to stop the spread of the disease.

What interested us especially in this discussion were the comments of both Max and Michael as they carried out a reevaluation of their program. Seven meetings were held, with area chiefs, headmen, community leaders, and traditional counselors. They discussed African culture with its customs and traditions. They asked themselves if these customs were possibly affecting their program negatively, and why so many people in their villages were dying in spite of their effort of information and warning. Max Church was not present, since they felt his presence would inhibit discussion of this sensitive topic.

It was found through these meetings that there are no less than seventeen different kinds of traditional "cleansing" rites practiced among the people involving sexual intercourse. They include young and old family members alike, at various times and occasions in the individual's lifespan, whenever it is felt that some kind of "cleansing from an evil spirit is required." These are tribal and family traditions, demanding such practices within the family structure itself, threatening serious consequences if not strictly followed.

They also discussed the problem of customary "waiting periods," required by tradition in connection with childbirth. These are periods when husbands must abstain from sexual activity with their wives for extended periods of time, and when as a result he often finds sexual satisfaction elsewhere.

Other problem areas had to do with *kuvinidwa* ceremonies, "nightgames," practices engaged in during wedding festivities and funerals. One might compare these activities with the "fertility rites" of ancient tribes that we read about in Scripture, customs which somehow or other worm their way into a society and involve sex in some way or other. Perhaps before one becomes too critical it would be well to ask ourselves if what we see and hear coming out of Hollywood these days is any different. Ex-Senator Dole recently described this quite

aptly when he accused the entertainment industry in America of becoming "coarse," speaking about "a line that has been crossed—not just of taste, but of human dignity and decency."

As a result of discussions of this kind questions arose as to whether or not a change of basic behavior was needed in order to get anywhere at all with this HIV/AIDS prevention program. Many of the elders, teachers, and traditional counselors had not equated the customs and traditions of family and tribe with sexual promiscuity. They had been taught that these customs were necessary to avoid making the tribal spirits angry. In a two-day session they spoke of these things and considered the facts about how this affected their very existence as a tribe. They concluded that somehow a change of behavior was needed for the good of village life. It developed later, Usi said, that a significant change began to show itself in the attitude toward these customs. They realized, in other words, that refusing to follow these customs did not result in death or disaster.

Our discussion with Usi led me to think about asking ourselves some of these same questions as well. To what extort are we aware of what's going on in connection with this battle between African tradition and Bible teaching? Do we really appreciate how deeply these problems reach into the life and behavior of the people, how difficult the battle is for them? It's something to ponder seriously, isn't it? It also leads me to conclude that the problem of HIV/ AIDS isn't going to be solved by a few informational lectures about the disease here and there. It's going to take much careful planning involving the national church, leading to the training of nationals to carry on the program. It's not going to be done in a hurry. But it does need to be addressed immediately by all concerned.

SOME CONCLUSIONS

As we come to this next to final chapter in our study of AIDS in Central Africa, a few summary comments would seem to be in order.

Officially Deborah Teuteberg and Joanne Halter have been commissioned by the Central Africa Medical Mission (CAMM) to "assess the needs of the AIDS crisis" and to "make a study toward developing and implementing a program to counsel and care for those infected with HIV." Our Mwembezhi Rural Health Centre under the direction of Sylvia Gustavison and Alfred Mkandawire has conducted a workshop on AIDS counseling in conjunction with the Zambia government's ZNASTL Programme.

We trust that the reports of these efforts will come before CAMM for consideration and action. I think we can also anticipate that the general reaction of CAMM will be positive, and that its recommendations relating to these reports will follow in due course.

This study of *AIDS in Central Africa*, undertaken by Kathie and myself; is really not the same kind of "official" report. It arose, as previously mentioned, out of a personal concern instigated through an informal discussion in Peru with Jim and Mary Olsen and has been funded by the Marvin Schwan Foundation. Kathie and I have come to Africa to gather information by listening to what the people here have to say, and to observe what has been done so far. As the various parties officially involved meet to deal with this matter, we would like to offer a few observations on our own and raise a few questions which we hope can help shed light on the entire situation of AIDS intervention:

AIDS Education

Much that has been done in central Africa by various governments and agencies in behalf of AIDS prevention has followed Western methods. HIV/AIDS education has been emphasized as the primary answer to the problem. Numerous materials for all age groups have been developed. Various ways of presenting these materials have been devised, including all sorts of informational tracts, booklets, stories, and illustrated study courses as well as comic books, dramas, and videos. While some of these materials can no doubt be adapted for our own use, we have found them totally devoid of dealing with the basic problem responsible for AIDS, which happens to be human behavior. The moral issue hasn't been faced squarely, Invariably the final answer in these materials lies in the wholesale distribution and use of condoms. While condoms can in some individual cases

serve a useful purpose, in many cases they merely add to the behavioral problem by encouraging illicit sexual relations.

Western education also presupposes that we have the best teaching methods of imparting knowledge without necessarily accommodating ourselves to the ways which work out best in Africa. It shouldn't surprise us, therefore, that the educational programs generally followed by governments and most agencies thus far have resulted in failure.

Our best tool as Christians lies, of course, in the one totally missing in the secular world, and that is the word of God. How, then, can the LCCA provide teaching materials that emphasize God's answer to young and old, men and women, youth groups and. church choirs as the only way to go? How can we place the emphasis on family relationships and marriage relationships that are pleasing to God? How can this teaching be imparted in our homes, congregations, and worker training institutions most effectively by taking into consideration ways which best fit the African context? Surely we need our African brothers and sisters to participate with us in this effort!

AIDS Counseling

The most effective programs that have been developed in HIV counseling so far have been through workshops involving the training of national community workers and individuals in HIV detection and care. The very words "HIV" and "AIDS" tend to frighten people away. How can people be encouraged to be tested for HIV? How can those who test HIV+ be counseled to avoid further spread of the disease? How can they be taught to continue living productive lives in whatever time remains? How can we most effectively use the Word of God to bring spiritual comfort where no earthly hope remains?

Again, this can best be done through our own LCCA trained pastors and trained national community health workers. Government programs have been placed at our disposal to utilize their expertise with trained workers as we see fit. Funds without strings have been made available for this purpose, as we have already experienced at Mwembezhi. We have our own people there who are not only medically trained, but who can add the essential ingredient, the comfort that comes from the word of God.

What we've often seen here is that the Western method of counseling has not been very effective. Setting up an office of some kind and expecting people to come to us doesn't work well here. This type of service seems to be better utilized when integrated into an existing system, i.e. Mwembezhi, and taken into the community via pastors and health workers.

How can the "Mwembezhi experience" be shared with our family of believers in the rest of the LCCA? How, in other words, can national health and community workers assist our pastors in the congregations throughout the synod? It's high time that these questions be seriously addressed.

African Culture and AIDS

The fact that African culture must be considered in correction with the whole AIDS situation goes without saying. In practically all plans and approaches to the problem that we have seen, it has not been taken into consideration seriously enough, and in some cases even avoided. There are African traditions, we believe, that could prove helpful (extended family, traditional systems of counseling, etc.). There are practices and traditions which are harmful (rites and ceremonies involving sexual behavior).

Other cultural factors referred to in our study involve the position of women in African society. In some cases the woman seems so subservient that she cannot even protest when her husband engages in illicit sex. When the husband dies, we have seen his family take over all remaining possessions and leaves her destitute. Women have frequently been spoken of as "so poor" that they take to prostitution for survival.

Once more, how can we address such cultural problems without involving the people here, through those among our own brethren who know much more about this than we do, and who need to share their

knowledge with us fearlessly and openly? What other influence but that which is taught in God's word can have an effect?

Admittedly one must realize that culture in Africa has many facets. Nowadays there is a decided difference between cultural influences in urban and in rural situations. Tribal customs also vary, and in Zambia we are dealing with as many as 80 cultural groupings. Complex? To be sure, but cultural issues need to be faced, and only the people here can advise us concerning them.

AIDS and Orphans

The problem of AIDS and orphans go hand in hand. Because of the malady many children are left homeless. We've heard about concerned people taking in homeless children. We've seen a woman taking babies into a private home, 60% of whom were doomed to die very soon. We've talked to a man who has identified 140 orphans in a one quarter section of Mtendere, a Lusaka compound in which one of our congregations exists. We know that there are LCCA pastors who in the extended family tradition have taken in the children of relatives in spite of the fact that they have many children of their own to provide for. We've seen many children on the streets of Lusaka, begging for food and learning how to be good thieves just to stay alive. We know of statistics of 500,000 to 800,000 orphans predicted in each of the countries in which our LCCA is working. What will happen to them?

At the moment we have no answers to this problem, not even good suggestions. We need to remind ourselves, however, that this problem is there, and that it is serious indeed.

The WELS and the LCCA

The Apostle Paul wrote in Galatians 6:10: "Therefore, as we have opportunity; let us do good to all people, especially to those who belong to the family of believers."

When our WELS medical mission program began in 1961 at Mwembezhi, it followed the apostle's encouragement to "do good to all people." The LCCA was in its infancy. Our health work was extended to all those in the community who were in need of our help, regardless of church affiliation.

The LCCA's membership has in the intervening years expanded from 200 or so to a family of believers numbering over 30,000. To what extent have we become aware of the second part of Paul's injunction, to do good "to those who belong to the family of believers"? Where does the "family of believers" fit into our health program as we think of it now? Do we shift our focus to the "family of believers" and forget about the original focus of "all men"? Must we do both? Can we? Questions have been frequently asked about this.

The firm commitment of the LCCA is vital to any extension of the medical mission program. The LCCA's greater participation in the work would be involved. A reevaluation would therefore seem to be in order, as the executive committee for the Lutheran Church of Central Africa, the committee of the Central Africa Medical Mission, and the leaders of the Lutheran Church of Central Africa consider how this work of medical missions can best be continued on a cooperative basis.

IS THERE HOPE ?

While I'm writing this in my temporary study room here in Zambia, there are 15,000 people meeting in Vancouver, Canada, interested in AIDS intervention in some capacity or other, and discussing the latest developments toward finding a solution to the problem. Many of those present at the recent AIDS Design Workshop in Lusaka mentioned that they would also attend. One can be sure that the delegates in Vancouver are hearing some fine motivational addresses, and eagerly awaiting news of the' latest results of AIDS research. There is always hope that medical science will have come a step further toward finding some miracle drug, as in the case of poliomyelitis. One has to be thankful that there are so many people genuinely concerned about this troublesome malady and putting forth their best efforts to end its spread.

Unfortunately in the meantime the epidemic continues to grow. Is there really any hope? We've raised the same question at the beginning of this study. From the very outset, of course, we have believed that mankind's only sure and lasting hope rests with God. He "will neither slumber nor sleep" (Ps 121: 4). With the Psalmist we also say, "I wait for the LORD, my soul waits, and in his word I put my hope" (Ps 130: 5). In the meantime even serious troubles can be tests of our faith. And beyond the transitory trials of this life we are assured of an eternal hope that will never fade away. "For our light and momentary troubles are achieving for us an eternal glory that outweighs them all," Paul declares (2 Cor 4: 17).

While still struggling in this world, however, our Lord instructs us not to think only of ourselves, but as his redeemed children to "do good to all people, especially to those who belong to the family of believers" (Ga 6: 10). It so happens that one of our synod's mission fields lies in the very countries where AIDS has struck its most devastating blows. A very special need exists right where we are, right where God has placed us.

A similar situation arose years ago, first in Zambia and then also in Malawi, when special health needs arose in our central African mission fields. Our synod responded with its medical mission program, which through the years has brought aid to countless thousands of people. We think of the dedicated service that has been given by those who have taken years out of their lives to work in our medical missions, the women of our synod who have responded so well in supporting this need, the committees that have freely given countless hours to direct the programs. Truly this has been the greatest humanitarian project undertaken by our synod in its entire history, and our God has richly blessed it. We might have said years ago, "What can we do? The job is too big for us. Let others take care of this need." I'm sure that all those who have participated in this work through the years have been thankful for the opportunity to have been involved in this service. It hasn't always been easy. but it's been rewarding. Our God has seen to that.

Now a similar situation has arisen. A special need exists, centered right in the fields where we are working. Our medical mission has been concerned enough to send two representatives, Debbie Teuteberg and Joanne Halter, both willing to take time out of their lives to travel ten thousand miles in order to assess the needs and make a study of what needs to be done for the care and counsel of those afflicted. I'm sure that their reports will reflect a serious situation, very similar to many of the things I have reported here.

I've already reported how Kathie and I became involved. Through the support of the Schwan Foundation and the interest of Dr. Heinz Hoenecke we were both encouraged to make the trip and give time to a study of AIDS intervention from a Christian viewpoint, something which seemed to be lacking in much of what was being done throughout the world. As I've reported before, we didn't know quite where or how to begin. We studied the facts of the disease itself, beginning with its ABCs. We reviewed the statistics, statistics which threaten that things will get worse before they get better. We were very much tempted at times to compare ourselves with Gideon's 300 men facing one hundred and thirty-five thousand Midianites, armed with nothing but trumpets; empty jars, and torches.

The deeper our involvement, however, the more we became aware of the rays of light that began to shine out of darkness. Daughter-in-law Margie was obviously frustrated, but willing nonetheless to amass a huge stack of informational materials, also reminding us that "with God we were not dealing with the impossible." Her materials showed a government extremely interested and concerned about the problem, though somewhat misguided in finding the solutions.

Son Ernie suggested certain aspects to look for in African culture, where much of the problem certainly lies, and prepared the way for precious interviews with LCCA church leaders. Good friend Tate Sauer came to visit us from America, as usual lending his sage advice and encouragement. Alone? Who can say that Kathie and I were alone as we began our struggles for information.

LCCA Chairman Kawiliza emphasized "family values" and "faithfulness in marriage" as points in need of special attention, and expressed an interest in the LCCA's involvement in dealing with the problem of AIDS. This involvement, of course, would have to be an essential ingredient if the work was to be carried out on an ongoing basis. Seminary Principal Hachibamba gave valuable insights into cultural aspects, also stressing that the whole matter of AIDS be given consideration in the church's teaching program, a teaching program which would include emphasis on sound law and gospel principles in dealing with the questions of AIDS. Pastor

Mpofu, without prompting of any kind, recommended the involvement of the national church on an organized basis in order to implement a training program for congregational leaders. The strong interest of some of the LCCA's leaders was encouraging. Things were definitely looking up.

Then, of all things, we found that a training program for community health workers had already recently been carried out at our Mwembezhi Lutheran Rural Health Centre, under the organizational leadership of Sylvia Gustavison with the faithful cooperation of Alfred Mkandawire, a program that enlisted experienced government presenters and NORAD funding. Things were already in progress!

The "unexpected bonanza," of course, bears mentioning again. What more could one want than to have been present at a gathering of professional leaders who were seeing things besides the sale of condoms as vital to AIDS prevention and care! The solutions recommended in their "design workshop," such as community involvement, behavioral change, and careful testing and counseling, agreed very much with what we also felt needed attention.

The trip to Malawi offered more rays of light. Through son Mark and his wife Louise we met people like George and James, Malawians who day after day visited a hospital to offer counsel and encouragement to AIDS victims. Without a doubt that's what it takes to measure up to one of the most trying and depressing tasks in the world. Their "Christian viewpoint" was refreshing to behold. And let's not forget Davona Church, the founder and director of Open Arms Infant Home with her Malawian "nannies." How would you like to care for a houseful of babies, victims of AIDS, who are doomed to die within a few months? Yes, there are people willing to do just that! The AIDS prevention program we ran into in Malawi with its struggles against culture and customs also gave us some insights into what needs to be faced when up against African tradition.

At times Kathie and I must confess that we got to feel a bit weary. Why not enjoy more of the glorious sunshine and the beautiful tourist havens that these countries have to offer? Kathie's assignment at the embassy and my teaching duties at the seminary kept us pretty much on the straight and narrow in any case. Why complain about something that wouldn't have been possible anyhow? Let's call them "blessings in disguise." My opportunity to teach eager seminary students every weekday morning offered more spiritual strength than I was perhaps ready to admit.

But let's return to our question. Is there hope? With a church that's alive and growing is there hope? With national leaders who are firmly grounded in the word is there hope? With twenty or more seminary students willing to leave their homes and devote themselves to prepare for the holy ministry is there hope? With a non-interfering and cooperative government should one complain? Rather than seeing all the obstacles and problems - and there certainly will be those - should we not rather appreciate how blessed we are and how much we have to share?

I can remember my very first attempt at writing for publication. This happened in my teenage years for a school paper. I chose the title, "Gutta lapidem cavat. " (Translated it means: "A droplet hollows out a rock.") Why not exhibit my Latin proficiency! Anyhow, I described how my father and I managed to fell a monstrous elm tree in our back yard with an axe, by chopping bit by bit. I may have mixed a few metaphors, but the moral of the illustration remains: a little time and effort, patiently and conscientiously done, can accomplish big things.

While,15,000 experts at Vancouver struggle to cope with the greatest physical disaster that has hit this world in many years, our little efforts may seem insignificant. But we have the LORD on our side. With him we can do all things. Yes, there is hope, more than we often realize.

The title of this presentation began with a question: "AIDS in Africa—Is There Hope?" We'd like to close with another question raised by Michael McKenzie in one of the most comprehensive articles we've read on the subject, entitled "ALDS: Reaping the Whirlwind" (*Christian Research Journal*, Summer; page 8). McKenzie asks, "It is clear that the AIDS epidemic is greatly affecting Christians. But the real question—and the one for which we are all responsible—is how, and to what extent, will Christians affect the AIDS epidemic?"

EPILOGUE

Copies of this AIDS study were given to a select group while Kathie and I were still in Africa - to those who contributed by means of interviews, to those who would be specifically involved in dealing further with the problem, and to those who expressed an interest in the results of our research. Reactions were generally favorable, indicating that our efforts had led to a better appreciation of the situation, as well as how one could possibly begin to deal with it.

After returning to America Kathie and I were surprised by the number of people who had somehow heard about our study and were interested in knowing more about what we had experienced. The many requests for our report were becoming more and more difficult to satisfy. Hence the printed pamphlet before you, which contains the story of our research efforts in both Zambia and Malawi, where the problem is so acute.

We are happy to add that responsible committees are now at work, engaged in taking the next steps toward AIDS intervention from a Christian viewpoint in central Africa. More is no doubt at stake than meets the eye. Committees and individuals, both at home and abroad, need to become involved in something new, something different, something which will require lots of patience, perseverance, and forbearance, often in the face of difficulties and frustrations. So very essential in efforts of this kind is the realization that we have the only sure help that is effective, and that we are trying to do with the Lord's help what needs to be done. The problem with which God has confronted us should not be a burden. It is rather an opportunity to provide assistance to those who have been afflicted, to offer help to those who would otherwise have no hope, to exercise Christian love in a time of desperate need.

Is something like this of more than of passing interest to those of us in America who live 10,000 miles away from the center of things? We think it is. We also need to remind ourselves that the problem of AIDS may be closer than we think. People often ask if AIDS is some special curse or punishment of God upon some particular kind of disobedience. The answer to questions of this kind needn't be all that argumentative. The Bible simply tells us: "Do not be deceived; God cannot be mocked. A man reaps what he sows. The one who sows to please his sinful nature, from that nature will reap destruction; the one who sows to please the Spirit, from the Spirit will reap eternal life"(Ga 6:7-8).

Also, before pointing too many condemnatory fingers at central Africa, let's ask ourselves seriously what kind of reaping and sowing is going on right here in America. Although we are not as yet as greatly afflicted by the AIDS malady as the people in central Africa, what can we possibly expect if our moral values continue to deteriorate as they have in the past few decades, particularly with regard to the sanctity of marriage and the adherence to solid family values.

Surely, what's going on in central Africa should urge us to pay all the more attention to the words of Paul in the verses from Galatians quoted above, which warn us against sowing to please our sinful nature, which can only reap destruction. We should also take note of the apostle's words which immediately follow this warning: "Let us not become weary in doing good, for at the proper time we will reap a harvest if we do not give up. Therefore, as we have opportunity, let us do good to all people, especially to those who belong to the family of believers" (Ga 6:9-10).

An opportunity lies before us not only to strengthen our humanitarian efforts to "do good to all people," but also to help those in Africa who "belong to the family of believers."